



**Co-operation Group to Combat  
Drug Abuse and Illicit Trafficking  
in Drugs  
(Pompidou Group)**

# **3<sup>rd</sup> Multi-city study**

**Drug use trends in 42 European cities in the 1990s**

Written on behalf of the Epidemiology Expert Group by  
RUUD BLESS

with contributions of  
UWE KEMMESIES  
STEVEN DIEMEL



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# EXECUTIVE SUMMARY



## INTRODUCTION

In the introduction we first sketch the origin of the Multi-city Study and its key objectives. The present report is the third Multi-city Study, covering the trends and developments of 42 cities in Western and Eastern Europe over the period 1991-1998.

We continue with a brief explanation of the multi-city reporting system, which is based on annual city reports by members of the Epidemiology Expert Group of the Pompidou Group. The core of these reports is the presentation of indicator data in pre-defined formats, supplemented by a methodological account of the data, a description of characteristics of the city as context for an interpretation of the data, and an assessment of trends and developments. The introduction concludes with an overview of the structure of the third Multi-city Study report.

## CITY PROFILES

The main body of this report consists of profiles of the individual cities that participated in the multi-city network at any time during the 1990s. Each profile starts with a short qualitative description of the city in terms of its geographical characteristics, history and patterns of drug use, drug interventions and (local) drug policy. This description provides a framework for the interpretation of indicator data and trends, which are presented in a standard format covering five domains: prevalence, treatment, health risks, drug law offences and drugs market.

City profiles are only included if we have data for at least one three years in the reporting period of which one year since 1996. Following these criteria the section on city profiles includes only 31 of the 42 cities. As the profiles by themselves are already a summary of the situation and developments of each city, we do not copy this information in the executive summary. Instead we make here some general remarks on the quality and completeness of these profiles.

For most of the cities we can only present partial information. Many indicator data are not available or they are only available for one or two years, which does not allow to assess trend developments. Context information varies greatly between cities both in scope and detail. There are several reasons for the rather patchy pictures of European cities. We mention a few.

- Participation in and contributions to the multi-city network during the 1990s has not always been consistent. Only a few cities have reported each year; not all cities adhered to the report formats demanded by the Guidelines of the Multi-city Study; some cities ended their participation in the mid 1990s, whereas others only joined the network in recent years.
- Although all indicators have been conceptually developed within the multi-city network as relevant descriptors of the drug situation, in many cases this has not been followed by implementation in local data collection systems. Due to a lack of resources or organisational structures data are not collected at all or only at a national level without provisions to extract data related to the city concerned.
- Several of the indicators were and are still “under construction”, meaning that report formats are still changing over time and in some cases no consensus has yet been obtained about definitions and preferred data collection methods.
- Although the importance of context information for the understanding of local situations and developments is widely acknowledged, discussions on the nature and extent of this information have only started recently. In reports of the first half of the 1990s “context” is largely absent or mainly interpreted as a more detailed verbal description of patterns and trends which are (also) described in figures in the indicator tables.

At this point it should also be remarked that the prime objective of the multi-city network in the past has been the methodological development of indicators and data collection. Within this focus there has not been much attention to fill the gaps where sound data do not yet exist. In the preparation of the third Multi-city Study report we have made a first attempt to fill these gaps by introducing informed expert estimates (see Interpretation below). This method is still a topic of discussion in the Epidemiology Group and we for this reason have not included these qualitative estimates in the city profiles.

Another factor that has contributed to the persistence of incomplete reporting in the multi-city network is the general orientation of the Epidemiology Group on description instead of analysis. Trends and developments at city level and across the network are traditionally inspected at face value; at city level in the “tour de table” presentations and discussions of individual cities during the meetings of the Group and across cities in the annual Synthesis Reports.

A scientific analysis of the data collected is not only inhibited by the large number of missing values in indicator data and time series, but even more so by the fact that the data are not accessible for analysis and that the Pompidou Group has only limited resources to create a multi-city database and to perform analyses.

These problems have been partly solved in the framework of this report in constructing a pilot database of indicator data from the over 120 city reports produced in the 1990s. We have used this database for an analytical exercise to demonstrate the potential of the data collection (see Analysis below) and it is the intention that the database will be updated regularly and become available for the scientific community in the near future.

## INDICATOR TRENDS

Figures and trends across Europe in the 1990s are presented in tables and thematic maps for a selection of indicators. Figures have been recalculated as rate per 100.000 to adjust for differences in population size of cities. The information is only presented when we have at least 10 cities to compare. Apart from the obvious incompleteness of data, already discussed above, we can make the following general observations:

- The magnitude of the phenomena measured by the indicators varies considerably between European cities, both within Western as in Eastern Europe.
- Where trends can be assessed most indicators and most cities show predominantly upward trends in the 1990s.

### Prevalence

Although prevalence of drug use can be considered as key information for comparisons between cities and implementation of drug policies and interventions, survey data are largely absent. Even when we have data, they are often not comparable. For only one element of prevalence –current cannabis use among school populations- we can present consistent recent figures, but only for 10 cities and only for 3 cities (Amsterdam, Gdansk, Lisbon) we can assess a trend.

### Treatment

Most cities do have treatment data and in particular data about first treatment demand. The quality and completeness of treatment data have been considerably improved in the second half of the 1990s following the elaboration of the indicator in a specific project of the Epidemiology Group in which 23 cities participated. In general treatment demand refers to opiate users. In most cities figures are rising, both for all treatment and first treatment demand. The main exception is Amsterdam where the trend in both cases is consistently downward over the 1990s. In general we can assume that treatment provision follows demand. Increasing treatment data therefore might indicate a growing need for treatment and an increase in problematic drug use. There are many reasons however to be cautious about such interpretations.



For several cities the trends also reflect the setting up and extension of treatment services to make up for the absence of appropriate services in the past. This applies in particular to cities in Eastern Europe where the implementation of specialised treatment interventions often only has started in the 1990s. Trends might also have been influenced by improvements of the data collection systems: in some cities treatment data of the late 1990s cover more centres than those of the early 1990s. Differences between first and all treatment demand figures might indicate such changes in coverage or extension of services, but they are also influenced by differences in treatment modalities.

Finally, treatment demand figures also reflect other responses to drug problems, like a diversion from criminal justice interventions to treatment interventions as indicated by the correlations between treatment and police arrest data.

### **Health**

Drug related mortality shows in many cities in the 1990s an upward trend, though there are positive exceptions. Recent figures vary between almost 20 (Oslo) to less than 2 (Paris, Sofia, St.Petersburg, Varna) per 100.000 of population.

Injecting drug use shows a downward trend in Western Europe but an upward trend in Eastern Europe. In general the percentage of injectors is higher in Eastern European cities than in Western European cities.

Incidence of drug related Hepatitis B increases in particular in many Russian cities, where also the highest incidence rates can be found. The increase might be related to better registration within an expanding treatment system (incidence is usually registered within a treatment setting), but the high relative figures as such might indicate a high level of injecting drug use combined with the absence of needle exchange programmes.

Data on incidence of Hepatitis C and HIV are only collected in the multi-city network since 1997 and at present we do not yet have sufficient data to present comparative trends. Incidence of Aids cases among drug users increased or remained stable over the 1990s, but due to the delay in sero-conversion figures and trends might not relate to actual drug use patterns in the 1990s.

### **Drug law offences**

In many cities trends in police arrests for drug law offences went up in the 1990s. This applies however mainly to Eastern European cities. Upward trends in the total number of arrests run often parallel with an upward trend in arrests for consumption offences. Arrests for cannabis related offences have also increased, in particular in Eastern Europe. Increased trends in police arrest are in many cases matched by a similar trend in court convictions for drug law offences.

### **Drugs market**

Market indicators are not widely available.

In general the number of seizures are increasing or stable for all drugs. Main exceptions are Stockholm and Malta, where seizures tend to decrease.

Information about the purity of drugs and prices of drugs at street level is even more rarely available. The information stems mostly from police sources. Consistency and reliability of the data can be questioned and so far the Epidemiology Group has not yet developed a commonly agreed method to collect this type of information.

## **AGGREGATE TRENDS: EAST-WEST COMPARISONS**

Both the city profiles and the indicator trends suggest substantial differences between Eastern and Western European cities. We have investigated this difference in trend patterns by aggregating the indicator data for all cities in each of these regions. This results in a marked difference between the regions, both with regard to the magnitude of indicators and the trend orientations, which confirms general observations that drug problems in Eastern Europe emerged on average 10-15 years later than in Western Europe. The average figures for East and West are

also presented in graphic format, which shows that in most cases the gap between Eastern and Western Europe is rapidly closing during the 1990s. At the end of the decade the average figures for Eastern Europe are almost at the same level as in the West.

Below we summarise the main differences.

### ***Treatment***

Higher figures for first treatment demand and non-fatal emergencies and lower figures for all treatment demand in Eastern Europe compared to Western Europe. Treatment demand indicators increased in the East, whereas in the West only all treatment demand shows an increase. The latter might reflect changes toward more long-term treatment modalities, e.g. substitution treatment.

First treated drug users in the East are younger than in the West. The trends in East and West are opposite: in Eastern Europe mean age decreases, in Western Europe mean age increases.

### ***Health***

Higher levels of injecting drug use in Eastern Europe and increasing, whereas in the West injecting drug use is less common and decreasing. This is matched by the figures and trends for incidence of Hepatitis B. For Aids present figures do not differ very much, though in the East incidence is rising; this seems consistent with the later start of drug problems in Eastern Europe and the time lag inherent to Aids incidence as indicator of drug problems.

Average figures for drug related mortality are about the same, but mortality is increasing in Eastern Europe.

### ***Drug law offences***

The differences in average figures between East and West are less outspoken. Arrests for trafficking offences increase in both regions; total arrests, consumption related arrests and convictions for drug law offences increase in Eastern Europe and remained stable in the West.

Western Europe shows more arrests for cannabis related offences, which indicates a less widespread use of cannabis in Eastern Europe.

### ***Drugs market***

With the exception of heroin, Western European cities show higher numbers of drug seizures than Eastern European cities. Trends in the west are stable, in the East they trends are going up, but not for cannabis.

## **ANALYSIS: RELATIONS BETWEEN INDICATORS**

As remarked above an analysis the data collection of the multi-city network is constrained by the large number of missing values. However, by using simple algorithms we are able to replace a number of missing data in time series by imputed values to obtain a dataset that allows at least some elementary statistical analysis.

We have investigated the interrelations between the indicators within each domain and between domains. At both levels we find a large number of significant correlations. Most of these correlations can be easily explained and confirm common knowledge in the field. For example with regard to relations within indicator domains: first treatment demand correlates with all treatment demand (when more people enter treatment, the total number in treatment increases); incidence of Hepatitis B correlates with injecting drug use (injecting is main risk factor for infection); convictions correlate with arrests (arrests precede sanctions by the criminal justice system). And examples between domains: treatment indicators correlate with health indicators (both treatment and health indicators refer to injecting drug use; incidence of infections is usually first registered in treatment); treatment data correlate with arrests (e.g. due to arrest referral

systems); arrests correlate with drug seizures (most arrests will involve some confiscation of drugs).

These relations between indicators have also been investigated separately for cities in Eastern and Western Europe and for large and smaller cities. The results confirm the previously found differences between East and West as well as the common perception that drug use and drug problems are typical metropolitan issues.

The impact of this type of analysis is not only that it can add to the interpretation of trends and developments, but also that it can contribute to the validation of the indicators. Although each indicator used in the Multi-city Study has an information value by itself, the set of indicators has in the first place been developed to indicate and monitor abstract concepts as “the drug situation” or “drug problem situation”. Within this context the interrelations between the present indicators also point out that they measure more or less the same aspect and some might be redundant.

Although we acknowledge the limitations of our analytical exercises on the fragmentary dataset of the Multi-city Study we have included them in this report to encourage and stimulate others to shift their focus from the continuing problems of data collection, which seem to be inherent to the phenomenon of drug use, towards more exploration of the limited data we do have.

## INTERPRETATION

In the last section of the third Multi-city Study we discuss the results of an “interpretation” among the experts of the Epidemiology Group. As mentioned before, we have added this survey to address some issues that are not or incompletely covered by the city reports of the 1990s.

### **Problem drug use**

In the expert survey estimates of problem drug use have been defined as users in need of treatment. Estimates vary from about 70 (Debrecen) to almost 1800 (Bratislava) per 100.000 of population. Compared with actual treatment figures (all treatment) in most cities only 10-25% of treatment need is assumed to be met; in Dublin and Paris this might be around 50%, in Amsterdam and Gdansk services might reach about 75% of the problem users. It should be remarked that for the last two cities the estimates of problem drug use are based on a formal capture-recapture model, which makes use of treatment data.

### **Prevalence of drug use; new and old drugs**

The experts have been asked to rank different drug types in following order of current prevalence among the general population and as primary drug among problem drug users, both according to the situation at the end of the 1990s and in the beginning of the 1990s. Results are presented as pyramids of illicit drug use for Eastern and Western European cities and for smaller and larger cities separately. Complementary to these rank orders of prevalences at the beginning and the end of the reporting period we also asked the experts for perceived trend developments with regard to individual drugs and to label drug types as new or old drugs in comparison to the situation in the 1980s.

The information provided indicates the following.

- Cannabis is and was the most common drug among the general population in Western Europe; in Eastern Europe inhalants used to be more common than cannabis, but at the end of the 1990s cannabis has also become the most widespread drug in the East.
- The traditional drugs of Eastern Europe, inhalants and opiate extracts, have been replaced during the 1990s by amphetamines and heroin.
- Heroin is both in the east and in the west the most prevalent problem drug.

- Cocaine use remains in Eastern Europe of low importance; in the West it has become the second most common drug after cannabis.
- The size of cities has no influence on the relative prevalences of particular drug types.
- In Eastern Europe most drugs are considered more or less as new drugs compared to the situation in the 1980s, whereas some see opiate extracts and inhalants as old drugs. In Western Europe no drugs seem to have disappeared during the 1990s, but many perceive ecstasy and crack as newly emerging drugs.
- Most drugs show an upward trend, both in the East and the West. Exceptions are inhalants and opiate extracts. Crack cocaine is relatively often reported as not being observed.

### **Epidemiological stages**

With the interpretation survey and the discussion of its results in the Epidemiology Group we have also attempted an exercise to explore an epidemiological model of drug use. In this model we distinguish five stages in the spread of psychotropic substances, which go parallel with increasing levels of prevalence.

- 1 *Endemic*: drug use strongly limited to certain age-cohorts, socio-economic groups AND geographic boundaries.
- 2 *Endemic-epidemic*: drug use exceeding over age-, social-, OR geographic-boundaries
- 3 *Epidemic*: drug use spreading over different age-cohorts, socio-economic groups OR geographic areas
- 4 *Epidemic-pandemic*: drug use not restricted (anymore) to clearly definable age-cohorts, socio-economic-groups AND geographic areas
- 5 *Pandemic*: drug use strongly spreading over different age-cohorts, socio-economic groups AND geographic areas.

The results of the survey indicate that at present cannabis use have reached stage 4 in Western Europe and stage 3 in Eastern Europe. The use of heroin and amphetamines might be at stage 2 in both Eastern and Western Europe. In Western Europe cocaine and ecstasy use is also assumed to be in stage 2. Other drugs do not yet pass stage 1.

As in the case of our analysis of relations between indicators, our exploration of diffusion patterns of drug use is only a first step towards an epidemiological model. Again, we have included the exercise in the third Multi-city Study report as an encouragement for further exploration.

### **General local drug situations**

As a final supplement to the body of information about local developments collected and presented in the past decade in the multi-city network of the Epidemiology Group we have ask the experts to classify the participating cities on a combined problem and control scale.

The results confirm again the general East-West divide in Europe. Most Eastern European cities are confronted with increasing drug problems not matched by intervention control. In Western Europe the experts perceive either decreasing problems or increasing problems, which remain however largely under control of appropriate intervention responses.

It should be noted at the same time that there are still more cities in the East than in the West which do not yet have any serious drug problems at all.

## CONCLUSIONS

For the Multi-city Study in the 1990s the most important development has been the expansion of the network to Eastern European cities since the mid 1990s. In general the expansion has been matched by an improvement of the multi-city data collection as Eastern European cities are more likely to adopt the Guidelines of the reporting system as the basis of their local data collection. Although most of the Russian cities joined the network only in the past two years, they still managed to complete time series of indicator data to cover most of the reporting period. At the same time we notice however decreasing levels of participation from Western European cities. Some ended their participation, others do not manage anymore to deliver complete city reports. This development in Western Europe is associated with a shifting focus from local towards national reporting systems since the establishment of the monitoring centre of the European Union (EMCDDA).

The larger number of cities in the network allows for more insight in trends and developments across Europe. In this report we have explored this in particular on the East-West dimension. On the other hand the growing number of cities also causes constraints for an inspection of trends. The expansion of the network has not been matched timely by changes in data collection, data storage and data presentation. The reporting mode –descriptive annual city reports on paper or in electronic form- remained largely the same. The revision of the Guidelines in 1998 did introduce more structure for the information to be presented, but did not result in a reduction of information nor in priorities regarding information. As a consequence the accessibility of the multi-city information has decreased. Overall pictures cannot emerge from reading and inspecting at face value a vast number of reports, notes and indicator tables about over 40 individual cities.

In the framework of the third Multi-city Study report we managed to make up for some of these complications by constructing a consistent database for the period 1991-1998. This might not have solved the structural problems of collection and storage of the multi-city data, but it allowed to present in this report comprehensive profiles of the participating cities, general overviews of European trends and tentative explorations of relations and developments.

As an overall picture from the information in the network as a whole in the 1990s we observe that,

- The use of illicit drugs has become a persistent phenomenon in Europe; regular use might still be quite rare, but experimenting and incidental use has become a common aspect of youth cultures across Europe. Eastern Europe catching up with the West in this respect seems to be an inevitable effect of the processes of democratisation and opening of frontiers after the fall of the communist regimes in those countries.
- In Western Europe where illicit drug use first emerged, the negative consequences of drug use (service demand, health implications, criminal justice interventions) tend to stabilise; the increasing trends in Eastern Europe go parallel with the still increasing trends in drug use due to the catching up with Western Europe up mentioned above.
- Differences in context (geography, policies, etc.) seem to have more effect on the negative consequences of drug use than on the level of drug use as such.



**2**

# **INTRODUCTION**





## OBJECTIVES OF THE MULTI-CITY STUDY

In 1982 the Ministerial Conference of the Pompidou Group installed the Epidemiology Expert Group to develop monitoring systems to evaluate the nature and magnitude of the problems created by drug abuse in the social and public health field.

From the start the Epidemiology Expert Group has adopted a city-based approach and the Group has operated as a multi-city network. This choice was based on the argument that the city level would be more suitable than the national level to develop and pilot appropriate monitoring systems. The smaller scale of cities makes it easier to account for the context needed to interpret facts and trends. Another argument was that in the beginning of the 1980s drug problems were mainly concentrated in urban or metropolitan environments.

Since 1983 the Epidemiology Group has presented and discussed each year a vast number of reports on individual cities and synthesis reports on trends across cities. These activities, which have become known as the Multi-city Study of the Pompidou Group, pursue the following objectives.

- To elaborate uniform methods and indicators, which describe patterns and developments of drug use and problem situations related to drug use;
- To explore characteristics and trends of drug use and related problems, by collating and comparing situations and developments across cities.

In the framework of the Multi-city Study the Epidemiology Expert Group has produced several reports on data collection methods and specific indicators, including accounts of scientific seminars about monitoring and methodological issues. This has resulted among others in a set of standardised indicators and report formats to monitor drug situations, which are published as the Guidelines of the Multi-city Study and form the basis of the annual city reports. Several of the indicator standards initiated and developed by the Group are today incorporated into the national monitoring systems of European countries and the key indicator reporting system of the European Monitoring centre for Drugs and Drug Addiction (EMCDDA).

In the periodic Multi-city Study reports the Epidemiology Group summarises and integrates trends and developments at city level across Europe over a period of years. The first Multi-city Study was published in 1987 and examined the validity, relevance and comparability of a number of indicators to evaluate trends of drug use. This first study covered 7 main European capitals - Amsterdam, Dublin, Hamburg, London, Paris, Rome, Stockholm- and presented developments up to 1985. With the second Study, published in 1994 and reporting on trends up to 1991, the number of cities had increased to 13, now also including Barcelona, Copenhagen, Geneva, Oslo, Helsinki and Lisbon.

The present third Multi-city Study deals with the period 1991-1998 and covers 42 cities. This major increase in the number of cities reflects the expansion of the scope of the epidemiological activities of the Group when in the 1990s most Eastern European countries joined the Pompidou Group and cities in those countries entered the multi-city network. Considering this development the third report gives special attention to differences between Western and Eastern Europe.

## THE MULTI-CITY REPORTING SYSTEM

The basic structure of the Multi-city reporting systems is set out in Guidelines that call for a standardised reporting. During the 1990s the Guidelines have been modified a few times and adapted to changing demands for information, feasibilities of data collection at city level and the need for more systematic reporting in order to cope with the growing number of participating cities. Over the years however the following topics have been the basic elements of the city reporting system:

- Indicator data related to drug use and drug problems
- Methods and data sources of indicator data
- Context information
- Trends and developments

### **Indicator data**

The indicator data are the core of the reporting system. The Guidelines provide definitions and report formats for each indicator. The indicators cover the following domains.

- *Prevalence*: prevalence figures based on both general population and school surveys; estimates of problem drug use;
- *Treatment*: first and all treatment demand; opiate substitution (since 1997); needle exchange and distribution (since 1997); drug related non-fatal emergencies; admissions to general and psychiatric hospitals (until 1996)
- *Health behaviour and health risks*: estimates of injecting drug use; drug related mortality; drug related morbidity (Hepatitis, HIV, Aids)
- *Drug law offences*: arrests for drug law offences; prosecution (since 1997) and convictions for drug law offences; drug users in prison (until 1996)
- *Drugs market*: drug seizures; prices and purity of drugs at street level

In the 3<sup>rd</sup> revision of the Guidelines (published in 1998 and effective for data of 1997 onwards) some indicators have been dropped while others have been added. New indicators have been introduced to cover important aspects of harm reduction policies (opiate substitution and needle exchange) or to better monitor developments in law enforcement (prosecution). A separate indicator on admissions to general and psychiatric hospitals is no longer necessary as the treatment indicator, which previously was restricted to specialised drug treatment services, now covers all treatment services and modalities provided to drug users. Finally, information on drug users in prison is no longer included based on the consideration that data of city-based prisons in most cases did not relate to local drug situation.

### **Methods and data sources**

In line with the methodological objectives of the Multi-city Study indicator data are supplemented by information about data sources, coverage of data and data collection methods. Information about these aspects is of crucial for the evaluation of data reliability and comparability.

To accentuate the importance of data methodology the 3<sup>rd</sup> revision of the Guidelines introduced a questionnaire format to collect this information for each indicator.

### **Context**

Indicator data reflect the environment in which they are collected. This context is important to understand data and to interpret trends in particular when indicator data are being compared between cities. Relevant context information may include demographic, socio-economic and socio-cultural characteristics of the city, local history of drug use, organisation and resources of intervention structures, developments in drug policy and drug laws as well as public responses and attitudes to drug use.

Although the need for context information is commonly acknowledged it remains difficult to decide which context information adds to a better understanding and comparability of indicator data. Comparative studies of drug use patterns accounting for the context of these patterns are quite rare. Until today most information on context is still collected in free format. Whilst this allows a great flexibility for the reporting expert to address aspects that might be relevant to his or her city, it limits comparative analysis as each expert might focus on different items. Recently the Epidemiology Group has started initiatives however to improve the scope and comparability of context information by organising interpretation workshops during its annual meetings.

### ***Trends and developments***

A summary of indicator trends and observations about new and disappearing trends with regard to specific drugs, patterns of use, risk groups and effects of drug use complete the city reporting system.

Until 1998 trend information was included in the indicator dataset and almost exclusively restricted to observed quantitative trends, which follow from changes in indicator data. The new Guidelines of 1998 however focus on qualitative information about trends and developments. In doing so the multi-city reporting systems not only calls on the participants of the Epidemiology Group to present city data but also to report about the city as informed experts.

### ***Limitations of the reporting system***

It should be remarked that the general outline of the reporting system above is not always matched by the actual city reports of the past years. In reality individual city reports vary considerably in scope, content and detail, due to the fact that the required information is not always available at city level and –probably more important- because of lacking resources to produce comprehensive annual city reports. Also, many of the improvements introduced in the 1998 Guidelines have not yet been accounted for in all reports presented up to date.

It should be noticed further that the multi-city reporting system traditionally has been restricted to objective quantitative indicator data or estimates based on sound scientific methods. This follows from the key objective to focus on methodology of indicator construction and data collection.

Although the availability of data has improved in the past decade all over the network, many cities still do not have data according to the standard indicators. As a consequence in most cases the reporting system only provides incomplete pictures of the situation and developments in cities. . More important, the large numbers of missing indicator data inhibit attempts to analyse patterns and trends across Europe.

As this situation is not likely to change very quickly in the near future, qualitative trend information has already been included in the new Guidelines of 1998 and in the framework of the third Multi-city Study report we also carried out a separate survey among the experts of the Epidemiology Group to supplement the available indicator data with informed expert estimates about a number of issues (see below). It will be a topic of discussion for the future if such type of estimates should be systematically included in the structure of the Multi-city study reporting system.

## **STRUCTURE OF THE 3<sup>rd</sup> THE MULTI-CITY STUDY**

The third Multi-city Study report presents an integrated overview of the developments in the cities, which participated in the multi-city network at any time during the 1990s. We present the information in three different ways.

- Section 3: City profiles
- Section 4: European trends
- Section 5: Analysis and interpretation

## **City profiles**

In this section we present a summary profile of the participating cities. The profiles are split into

- context;
- indicator data and trends.

*Context* is based on the corresponding section of the underlying city reports. In most cases we have used the latest report available. *Indicator data and trends* present the most recent indicator data and a graphic display of trends in indicator data. As we do not consider data prior to 1996 as relevant recent information for a report to be published in 2000 and require for trends data of at least three different years in the reporting period, city profiles can only be presented for 31 of the 42 cities that participated in the network in the 1990s.

## **European trends**

In this section we present trends across Europe in two different ways.

- (4.1) Indicator trends
- (4.2) Aggregate trends

*Indicator trends* present for each indicator the most recent data (since 1996, see above) and the trends per city. To allow comparisons between cities, indicator data have been standardised as figures per 100.000 of population. Trend developments are assessed on the basis of a statistical model and presented as a simple ordinal scale of up, down and stable in table and map formats.

In *Aggregate trends* we give graphic presentations of average trends in indicators (again standardised as rates per 100.000 of population) in Eastern and Western European cities. This choice to compare East and West at aggregate level is based on the observation in 4.1 of clear differences in the magnitude of indicator rates between Eastern and western European cities and also accounts for the change in the scope of the Pompidou Group in the 1990s caused by the joining of Eastern European countries.

## **Analysis and interpretation**

We conclude the report with a tentative attempt to analyse and interpret trends in the multi-city network in the 1990s. We call this a tentative attempt as we have to acknowledge that the data collection of the multi-city study does not really meet all requirements for scientific (statistical) analysis, mainly due to the large number of missing values, both across cities and years included in the time series 1991-1998. This section is divided into

- (5.1) Analysis
- (5.2) Interpretation

In *Analysis* we investigate the interrelations between the indicators of the reporting system. For this analysis we have tried to overcome the shortcomings of the multi-city data collection by the imputation of missing data in time series of individual cities.

*Interpretation* deals with an exploration of trends and developments, which until now cannot really be covered by the data collection of the multi-city study but are considered to be key topics for future development of the multi-city reporting system. The exploration is based on a survey and subsequent discussions among the experts of the Epidemiology Group in 1999. It addresses the following issues:

- problem drug use and in particular the question to which extent service needs are matched by service provision
- changing patterns of prevalence and the emergence or disappearance of particular drug types
- epidemiological stages in drug use
- general assessment of local drug situations

Following the observations of section 4 about differences between Eastern and Western Europe we try in both the Analysis and Interpretation to differentiate in developments and situations between East and West.

We realise that the methods applied in section 5 may cause scientific critics and discussion. We believe nevertheless that the exercises presented, even within the constraints of limited and imperfect data, can contribute to further elaboration of relevant and meaningful reporting in the complex field of drug use and can stimulate others to use indicator data to develop explanatory models.



**3**

# **CITY PROFILES**





## ACCOUNT OF DATA PRESENTATION

In this chapter we present profiles of cities on which the experts of the Epidemiology Group have reported in the period 1991-1998. Each profile consists of two sections:

- *Context information*
- *Indicators and trends*

The purpose of the profiles is to provide a quick overview of trends in the 1990s, recent indicator data and context information. The information presented is a very summarised selection of city reports delivered by the experts in the 1990s. The selection also reflects the fluctuations in the participation of cities in the Multicity network. Some cities ended their participation in the 1990s, others have joined the network and many cities did not present (complete) reports each year.

### Context information

Understanding trends in indicator data requires information on the context in which these trends emerge. Although the need for this type of background information has been acknowledged in the Multicity network from its beginning, context information is often neglected due to the network's focus on indicator data and associated data collection problems. In the first half of the 1990s context information was largely absent in the city reports. After the introduction of the New Guidelines in 1997, which include an array of specific questions on context, most city reports do include context information, but they also reveal that we do not yet have clear concepts about scope, detail and relevance of such information. As a consequence the level of available context information varies considerably between cities.

Here we present for each city in abstract form and as far as available information on:

- *Geography*
- *History and patterns of drug use*
- *Drug interventions and policy*

The topic geography intends to cover demographic, socio-economic and related aspects, but remains in most cases very rudimentary. With regard to history and patterns of drug use and interventions we have tried to avoid duplication of information that in principle can also be read from the indicator and trends.

### Indicators and trends

All *indicator values* refer to 1998 unless otherwise indicated in italics next to the figures. However, the cut-off point for 'recent' data has been set arbitrarily at 1996; if the latest available figure dates before 1996 no data are presented.

*Trends* are presented in graphic format, but only if we have at least 3 annual figures for one of the data included in graph. Trend graphs however do cover data prior to 1996.

As a consequence of these selection criteria we only include profiles for 31 of the 42 cities that participated in the Multicity network at any time in the period 1991-1998.

For simplicity legends have been omitted in trend graphs. Bars and lines correspond to the items listed in the adjacent indicator tables and match the colour of the boxes next to these items.

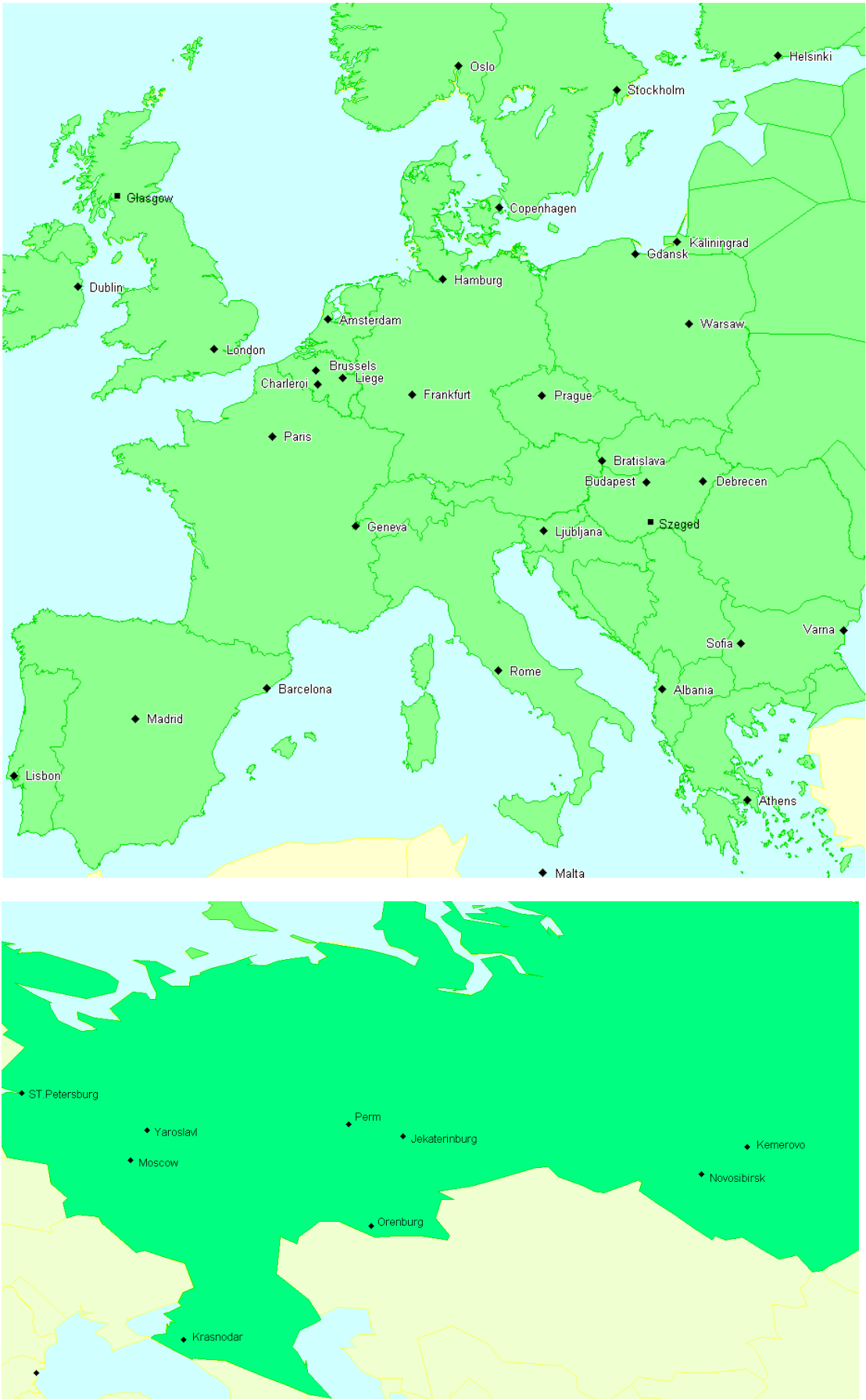
The trend graphs only intend to present relative developments of the indicator data at city level and not to 'read' actual figures. The X-axis corresponds in all cases to the time series 1991-1999, but the scales of the Y-axis can vary between graphs and across cities. The trend graphs therefore do not allow comparisons with regard to the magnitude of different indicators of one city nor with regard to the magnitude of identical indicators across different cities.

### Multicity network 1991-1998

The following map and table gives an overview of the cities that have participated in the Multicity network in the period 1991-1998. The table also marks for which cities profiles are included and lists the names of the epidemiology experts who prepared the original city reports.

In two cases city profiles have been replaced by a country profile: Albania because of current problems in data collection at local level, and Malta because the urban area and population more or less coincides with the country as whole.

Overview of cities participating in the Multicity network 1991-1998



Overview of cities participating in the Multicity network 1991-1998

city	country	profile included	authors of city reports in the 1990s
ALBANIA	Albania	●	<i>Eduard Kakarriqi, Z.Sulaj</i>
AMSTERDAM	Netherlands	●	<i>Peter Cohen, Ruud Bless, Steven Diemel e.a.</i>
ATHENS	Greece	●	<i>Anna Kokkevi, Kyriaki Politikou</i>
BARCELONA	Spain	●	<i>Teresa Brugal, Joan Caylà, Luis Torralba</i>
BRATISLAVA	Slovak Republic	●	<i>Alojz Nociar</i>
BRUSSELS	Belgium		<i>Mark Vanderveken</i>
BUDAPEST	Hungary	●	<i>Eva Katona, Katalin Veress,</i>
CHARLEROI	Belgium		<i>Benoît De Clerk</i>
COPENHAGEN	Denmark	●	<i>Elisa Dall, Dorrit Schmidt</i>
DEBRECEN	Hungary		<i>Zsuzsa Varsavovski</i>
DUBLIN	Ireland	●	<i>A.O'Hare, K.O'Higgins, Mary O'Brien e.a.</i>
FRANKFURT	Germany		<i>Oliver Müller</i>
GDANSK	Poland	●	<i>Jacek Sekiewicz</i>
GENEVA	Switzerland	●	<i>Dominique Hausser, Isabelle Renschler</i>
GLASGOW	United Kingdom		<i>Martin Frischer</i>
HAMBURG	Germany	●	<i>K.J.Lange</i>
HELSINKI	Finland	●	<i>Osmo Kontula</i>
JEKATERINBURG	Russia		<i>J.Ruzhnikov</i>
KALININGRAD	Russia	●	<i>V.Amenitsky</i>
KEMEROVO	Russia	●	<i>A.Seledtsov</i>
KRASNODAR	Russia	●	<i>V.Kolesnikov, I.Koikova</i>
LIEGE	Belgium		<i>Luc Bils, Isabelle Noirfalisie e.a.</i>
LISBON	Portugal	●	<i>Luisa Rodrigues, C.Antunes, Z.Mendes e.a.</i>
LJUBLJANA	Slovenia	●	<i>Dusan Nolimal, T.Jerman, Miljana Vegnuti e.a.</i>
LONDON	United Kingdom		<i>Richard Hartnoll, Paul Griffith e.a.</i>
MADRID	Spain		<i>Plan Municipal sobre las Drogas</i>
MALTA	Malta	●	<i>Richard Muscat</i>
MOSCOW	Russia	●	<i>Eugenia Koshkina, A.Shamota</i>
NOVOSIBIRSK	Russia	●	<i>R.Terkulov</i>
ORENBURG	Russia	●	<i>Andrej Karpets, V.Karpets</i>
OSLO	Norway	●	<i>Astrid Skretting</i>
PARIS	France	●	<i>M.Toussirt, R.Ingold, F.Facy, A.Toufik e.a.</i>
PERM	Russia	●	<i>S.Elovikov, V.Sokolov</i>
PRAGUE	Czech Republic	●	<i>Ladislav Csémy</i>
ROME	Italy		<i>Ustik Avico, Laura Camoni e.a.</i>
SOFIA	Bulgaria	●	<i>Philip Lazarov</i>
STOCKHOLM	Sweden	●	<i>Börje Olsson</i>
ST.PETERSBURG	Russia	●	<i>Galina Korchagina, Y.Vasiliev</i>
SZEGED	Hungary		<i>Károly Zelenai, György Talabér</i>
VARNA	Bulgaria	●	<i>Gueorgui Popov</i>
WARSAW	Poland	●	<i>Janusz Sierolawski, Antoni Zielinski e.a.</i>
YAROSLAVL	Russia	●	<i>V.Melnikov</i>

**Population:** 3,249,000 (1995)

### **Geography**

Until 1912 Albania was a very poor and very rural province of the Ottoman Empire. It gained independence in 1912. In 1944 it became a communist state. Communism in Albania took an extreme Stalinist form, which led to international isolation. The victory of democracy in 1992 marked an opening towards free movement of ideas and people. However, the situation remained and remains fragile. In 1997 Albania experienced much social unrest and internal armed conflicts. The country is still in a process of demographic, social and economic transition.

Albania is rapidly changing from a rural into an urban society. Population pressure is noticeable in the coastal plains. The population of the capital Tirana increased from 350,000 in 1994 to 700,000 in 1998. Emigration, virtually non-existent until 1989, is a conspicuous phenomenon during the 1990s. Birth rate and infant mortality resemble those of developing countries, life expectancy however is comparable with developed countries. In similar way morbidity patterns, with communicable diseases at first place, are typical for developing countries whereas mortality represents epidemiological patterns of a developed country.

Albania's economy completely collapsed in the early 1990s. The economic reforms initiated in 1992 paved the way of a recovery, but at high social costs. The GDP of \$ 766 in 1996, though much higher than the \$ 213 of 1992, is the lowest of all European countries. Unemployment is high, especially among the youth. Participation in education declined in the 1990s due to an increasing number of dropouts related to the establishment of family businesses and farms at the introduction of a market-economy, internal migration and emigration.

The unrest and turmoil of 1997 aggravated the overall social-economic situation. Organised crime appeared, including networks of drug dealers. The prominent changes in the political and economic arena also brought about changes in social life and traditional values.

### **History and patterns of drug use**

In the years before 1993 drug use and drug problems were sporadic insignificant phenomena in Albania. Since there is an exponential increase, especially following the conflicts of 1997. Today there is an established drugs market in the country.

### **Drug interventions and policy**

In Albania still exists only one specialised centre for both inpatient and outpatient treatment, the Toxicological Clinic of Tirana University Hospital Centre (TUHC). The Psychiatric Clinic of the same TUHC does not deal with drug treatment.

There are two structures of drug law enforcement: the most important is the Anti-Drug Unit of the Ministry of Public Order (Ministry of Interior); the other is the Anti-Drug Unit of the National Directory of Customs (under the Ministry of Finances).

In the new Penal Code of the Republic of Albania (1996) traffic, production and sales of illicit drugs are considered as punishable penal acts and criminal offences against the public order and public security. Sanctions can go up to prison terms of 15 years.

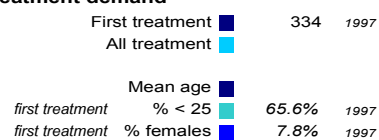
Since 1996 there is National Committee against Drugs, composed by the ministers of all the ministries involved in the drugs fight. Also a National Centre of Drugs Information Systems has been created.

## PREVALENCE

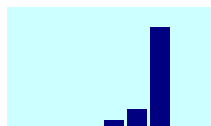
no (recent) data

## TREATMENT

## Treatment demand



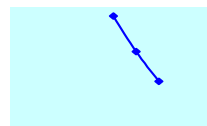
## First and all treatment



## Mean age and % &lt; 25



## % females



## HEALTH

## Injecting drug use



## Prevalence of IDU

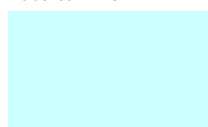


## Infectious diseases



## % IDU infected

## Incidence in IDU

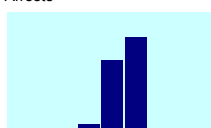


## DRUG LAW OFFENCES

## Arrests for drug law offences



## Arrests

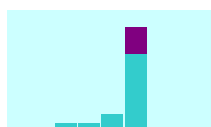


## DRUGS MARKET

## Drug seizures



## Number of seizures



**Population:** 727,000 (1999)

### **Geography**

Capital of the Netherlands (but not the seat of the government). Amsterdam is an international financial, commercial, tourist and cultural centre. Nearby Schiphol is one of the main European airports. The city has several centres for higher education, including two universities. About 45% of the population is of non-Dutch origin.

### **History and Patterns of drugs use**

In the late 1960s cannabis and LSD were introduced when the city was a centre of alternative subcultures. In the early 1970s the first users of heroin and amphetamines appeared. Users (and dealers) of Surinamese origin played a major role in the widespread diffusion of 'chasing the dragon' (inhaling the vapours) among the Dutch heroin-using population. Together with the rapid response of accessible methadone provision this route of administration probably contributed to the consistent relatively low number of drug-related deaths. After a peak in the mid-1980s, a steady decrease of the numbers of heroin users can be observed.

The use of cannabis is widely accepted. Amsterdam has many so-called 'coffee-shops' where cannabis can be purchased in small quantities for personal use. This is tolerated within the Dutch legal system and originates from a policy to split the markets of hard drugs and soft drugs. Parallel to the emergence of new dance subcultures in the 1990s, ecstasy has become the second most popular illicit drug after cannabis among the youth population. In the late 1990s experimental use of new (semi-legal) drugs such as psychedelic mushrooms increases.

In the late 1990s the use of crack cocaine has also established among some groups of street drug users.

### **Drug interventions and policy**

Low-threshold provision of methadone started in the late 1970s. Today the majority of heroin users participate in methadone substitution programmes. Methadone is provided by specialised agencies as well as local GPs; it is also delivered to addicted arrestees at police stations and in prisons.

During the AIDS epidemic in the 1980s syringe exchange programmes have been initiated. The Municipal Department of Public Health operates several special programmes for subgroups of the drug using population (addicts admitted to general hospitals, prostitutes, homeless users), provides back-service to methadone prescribing GPs and participates in an experiment of heroin prescription to long-term poor-functioning heroin users. The Jellinek Centre is the main institute for outpatient and inpatient treatment and care.

Amsterdam has a central system of monitoring drug users in treatment and care. Since the early 1990s the Jellinek Centre also maintains a monitoring system (Antenna) on drug use among young people.

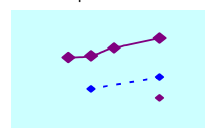
Dutch municipalities have executive powers to develop their own local drug policies. The Amsterdam drug policy for the last twenty years has a dual focus on both public health (harm reduction) and public order (nuisance reduction). There is an active coordination between actors and actions in the domains of public health, specialised drug services, police and justice. As the municipality finances almost all drug services, budget allocation is a major policy instrument. Another important policy instrument is the wide application and enforcement of local by-laws to reduce drug related nuisance.

## PREVALENCE

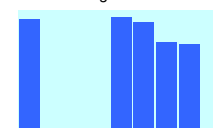
## Cannabis use

	general population	school population
Ever (LTP)		
Recent (LYP)	13.4% 1997	
Current (LMP)	8.3% 1997	23.0% 1997

## Cannabis prevalence



## Problem drug users



## Problem drug use

Prevalence estimate	5018
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## TREATMENT

## Treatment demand

First treatment	472
All treatment	2018

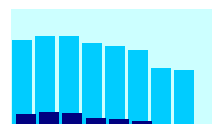
first treatment	Mean age	30.1
first treatment	% < 25	9.1%
first treatment	% females	24.8%

## Opiate substitution

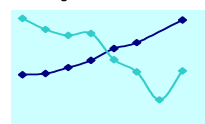
First substitution	203
All substitution	3053

first treatment	Mean age	34.2
first treatment	% < 25	14.8%
first treatment	% females	27.6%

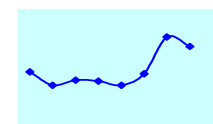
## First and all substitution



## Mean age and % &lt; 25



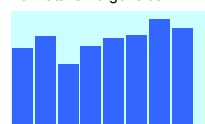
## % females



## Hospital episodes

Psychiatric hospitals	
General hospitals	
Non-fatal emergencies	603

## Non fatal emergencies

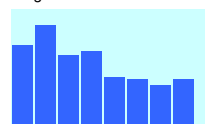


## HEALTH

## Injecting drug use

Estimated IDU prevalence	20.5%
reference unknown	

## Drug related deaths



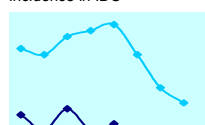
## Mortality

Drug related deaths	25
---------------------	----

## Infectious diseases

	incidence in IDU	% IDU infected
Hepatitis B		
Hepatitis C		
HIV		
Aids	10	11.8% 1997

## Incidence in IDU

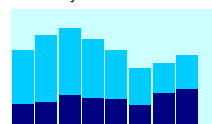


## DRUG LAW OFFENCES

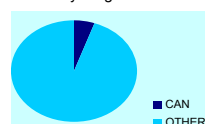
## Arrests for drug law offences

Trafficking	1571
Consumption	1228
Total arrests	2799

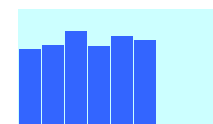
## Arrests by offence



## Arrests by drug



## Convictions



## Convictions for drug law offences

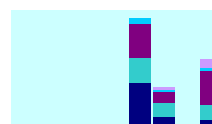
Total convictions	892 1996
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## DRUGS MARKET

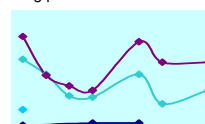
## Drug seizures

Cannabis	437 1999
Heroin	555 1999
Cocaine	1243 1999
Amphetamines	102 1999
Ecstasy	328 1999

## Number of seizures



## Drug prices



**Population:** 3,073,000 (1991)

### Geography

Capital of Greece. In the administration Athens only exists as Greater Athens, a conglomeration of 55 municipalities, including Piraeus, the main port of Greece. The process of massive urbanisation and population growth of the 1970s has been reduced to a moderate pace in the 1990s. Greater Athens is the main commercial and industrial centre of Greece. Tourism also plays an important role in Athens' economy. According to the 1991 census the unemployment rate was 8.4%. This figure might have increased in recent years. Apart from being the economic centre of Greece, Athens is a great cultural, intellectual and artistic centre.

### History and Patterns of drugs use

Illicit drug use was very limited until the 1970s and mainly confined to certain sections of the working-class population. There was a significant increase in illicit drug use from the mid-1970s, which spread widely into various socio-economic groups. Since the late 1970s the use of drugs, especially opiates and licit psychotropic substances, started spreading among younger age groups. The use of non-prescribed psychoactive drugs was rather high because the legal status of their prescription was not well defined until the mid-1980s, but it has decreased since.

Although cannabis is the most widespread illicit drug, survey data show that among the general population the highest prevalences are still found for (non-prescribed) psychoactive medicines (tranquillisers, barbiturates, antidepressants, etc.). Among pupils aged 14-18 years solvents are more popular than cannabis. Heroin is the most prevalent drug among dependent individuals. The sharp increase of drug-related deaths in the mid-1990s might be a delayed consequence of the spread of the heroin epidemic since the mid-1980s as well as a result of the high prevalence of injecting. It is estimated however that in the second half of the 1990s injecting drug use is decreasing.

### Drug interventions and policy

Up to 1983 in-patient detoxification was the most important service, but today a wide variety of services are in place. The first national law (1987) that dealt thoroughly with the problem of expanding drug use considered the drug dependent as a 'patient' instead of a criminal and covered all aspects of the problem with an emphasis on 'de-stigmatisation'. Consecutive laws have strengthened this policy by setting up more intervention services and structures and by introducing more severe penalties for trafficking. Provisions have been made for counselling centres, prevention services as well as facilities for monitoring the drug situation.

The law of 1993 legalised substitution treatment in special units and created the Greek Organisation for Combating Drugs (OKANA), a private sector organisation under the Ministry of Health with executive powers to coordinate programmes, in which local authorities, specialised agencies, police and justice participate. The law of 1995 placed particular emphasis on therapy, introducing the postponement of the penal prosecution of drug law offenders provided that they have voluntarily entered and systematically attended treatment. Further refinements to the intervention strategies were made in a law of 1998.

A first opiate substitution programme started in Athens in 1996. It has been expanded in 1998 and further expansion is foreseen. Streetwork and syringe exchange appeared in 1997.

Since 1996 there is a debate among professionals and politicians on a legal distinction between soft and hard drugs and the expansion of methadone programmes.



## PREVALENCE

## Cannabis use

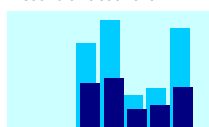
	general population	school population
Ever (LTP)		
Recent (LYP)		
Current (LMP)	2.5%	8.2%

## TREATMENT

## Treatment demand

First treatment	300
All treatment	687
first treatment Mean age	34.1
first treatment % < 25	38.0%
first treatment % females	18.7%

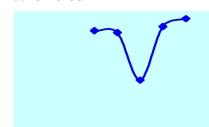
First and all treatment



Mean age and % &lt; 25



% females



## Opiate substitution

First substitution	91
All substitution	314
first treatment Mean age	40.0
first treatment % < 25	3.3%
first treatment % females	17.6%

## HEALTH

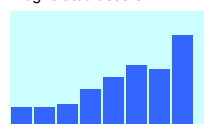
## Injecting drug use

Estimated IDU prevalence	52.2%	1997
reference: first treatment		

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths	239
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## Infectious diseases

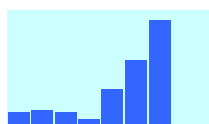
	incidence in IDU	% IDU infected
Hepatitis B		
Hepatitis C		
HIV		
Aids	3	3.6% 1997

## DRUG LAW OFFENCES

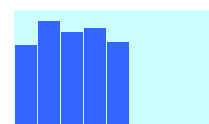
## Arrests for drug law offences

Trafficking	
Consumption	
Total arrests	4580 1997

Arrests



Convictions



## Convictions for drug law offences

Total convictions	
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## DRUGS MARKET

no (recent) data

**Population:** 1,509,000 (1995)

Recent context information is not available; the latest report including a general description of the local situation however dates from 1992. The city operates since the late 1980s an elaborated and consistent drug information system. In the past Barcelona has provided detailed annual indicator data reports for the Multicity network, but the city ended its participation in 1996. For the purpose of the 3<sup>rd</sup> Multicity Study the project coordinator nevertheless received additional indicator data for 1997.

## PREVALENCE

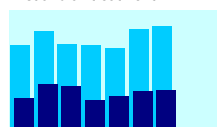
no (recent) data

## TREATMENT

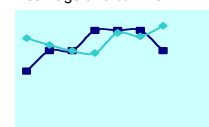
## Treatment demand

First treatment	1362	1997
All treatment	3468	1997
first treatment	Mean age	28.0 1997
first treatment	% < 25	34.8% 1997
first treatment	% females	22.0% 1997

First and all treatment



Mean age and % &lt; 25



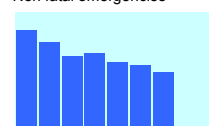
% females



## Hospital episodes

Psychiatric hospitals		
General hospitals		
Non-fatal emergencies	3028	1997

Non fatal emergencies

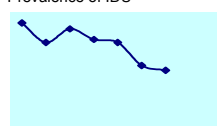


## HEALTH

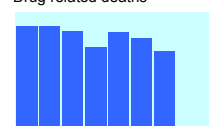
## Injecting drug use

Estimated IDU prevalence	41.5%	1997
reference: all treatment		

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths	122	1997
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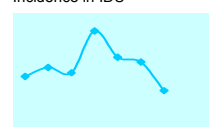
## infectious diseases

incidence in IDU

% IDU infected

Hepatitis B		
Hepatitis C		
HIV		
Aids	162	1997

Incidence in IDU



## DRUG LAW OFFENCES

no (recent) data

## DRUGS MARKET

no (recent) data

**Population:** 451,000 (1995)

### **Geography**

Capital of the Slovak Republic, located near the Austrian and Hungarian borders. Commercial, industrial and cultural centre of the country. Unemployment rates in the 1990s: 4-6%.

### **History and Patterns of drugs use**

Until the late 1980s illicit drug use was a hidden phenomenon, probably limited to some small groups. Since 1989 Bratislava gradually became a transit point of trafficking in psychoactive substances. In the 1990s cannabis and heroin use spread among young populations. Problem drug use shifted from pharmaceutical drugs to heroin. In 1993 treatment demands of predominantly young heroin users dramatically rose. Treatment capacity expanded and in 1997 their number is more than tenfold of 1992.

Today cannabis is the main illicit drug. Surveys indicate increasing lifetime prevalence rates for all types of drugs. According to school survey data solvents/inhalants and sedatives/tranquillisers are the most popular drugs after cannabis. Most heroin users are still very young. Because of the high prevalence of injecting and needle sharing, there is a growing fear for the spread of HIV and Hepatitis B and C among users in the future.

### **Drug interventions and policy**

Up to 1990 treatment for drug users was provided by the Anti-alcohol Counselling Centre, but specialised treatment, health and social care services and prevention programmes for drug users have been developed since. In 1994 a small programme of needle exchange was started and continued and drug prevention at schools was introduced. In 1997 the first methadone programme was initiated.

In 1995 the National Programme for Combating Drugs was established, which operates by a system of regional and districts commissions. In 1994 the Act Against Organised Crime was introduced and articles on drug production, trafficking and possession in the Penal Code were revised. Since 1998 a new law on psychoactive substances is in force and a Law on Precursors will soon be approved. The drug legislation leads in some circumstances to the criminalisation of drug users, although the consumption of drugs is not penalised.

## PREVALENCE

## Cannabis use

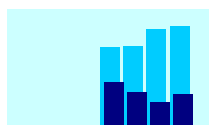
	general population	school population
Ever (LTP)		
Recent (LYP)		
Current (LMP)	3.9%	8.5%

## TREATMENT

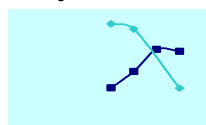
## Treatment demand

First treatment	362
All treatment	1026
first treatment Mean age	21.9
first treatment % < 25	34.8%
first treatment % females	30.9%

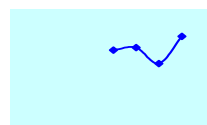
First and all treatment



Mean age and % &lt; 25



% females



## Opiate substitution

First substitution	
All substitution	140
all treatment Mean age	21.8
all treatment % < 25	
all treatment % females	22.9%

## HEALTH

## Injecting drug use

Estimated IDU prevalence	77.9%
reference unknown	

## Mortality

Drug related deaths	18
---------------------	----

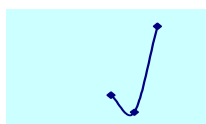
## infectious diseases

	incidence in IDU	
Hepatitis B	6	1997
Hepatitis C		
HIV		
Aids	0	1997

% IDU infected

0.7% 1997

Incidence in IDU

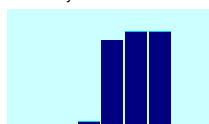


## DRUG LAW OFFENCES

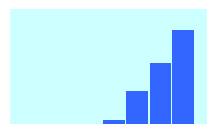
## Arrests for drug law offences

Trafficking	490	1997
Consumption	4	1997
Total arrests	494	1997

Arrests by offence



Convictions



## Convictions for drug law offences

Total convictions	496
-------------------	-----

## DRUGS MARKET

## Drug seizures

Cannabis	22
Heroin	79
Cocaine	4
Amphetamines	2
Ecstasy	1

**Population:** 1,886,000 (1998)

### **Geography**

Capital city of Hungary. Commercial, industrial and cultural centre of the country. Growing tourist industry with rapid proliferation of bars, discos and other entertainment centres. Unemployment rate: 5%. Due to the economic crisis real income has significantly decreased in the 1990s.

### **History and Patterns of drugs use**

In the second half of the 1960s inhalants were the most common used substances among young people. By the end of the 1970s the drug scene consisted of poly-drug users of inhalants, alcohol, and pharmaceutical drugs. Since the 1980s opiates such as home made preparations of the poppy plant and heroin, followed by stimulants, are the most common drugs in the scene. In the 1990s illicit drug use is increasing among several subpopulations. Increased drug use goes parallel with the developing market economy, economic crisis, confusing health care reform, flimsy social networks. Growing supply and the emergence of new youth subcultures increased the use of cannabis and ecstasy among youngsters, while volatile substances remain popular. Abuse of pharmaceutical drugs remains widespread too, partly due to liberal rules regarding the prescription of medicines. The use of 'Polish kompot' (homemade opiate extract) is diminishing. Homeless young adults using solvents have been identified as a new risk group.

### **Drug interventions and policy**

Budapest has a variety of treatment facilities, covered by the national health care system. In general, treatment is aimed at abstinence. Since 1989 methadone is prescribed in detoxification but there are no official methadone maintenance programmes. In the 1990s low-threshold care facilities and projects have been developed. A needle exchange programme was started in 1995. In 1994 a mobile Drug Prevention Bus was initiated, aimed at youngsters, parents and teachers. A shift towards a medical-social perspective on drug use led to a revision of the drug legislation in 1993. This includes more severe penalisation of trafficking and related crimes, while for drug users (abstinence oriented) treatment instead of imprisonment can be considered. Today's national drug policy balances supply and demand reduction. Attitudes and views of police and treatment system have become less polarised. Only recently local policy making is developing, but still lacking the framework of a coherent national strategy. At present the Budapest local government attempts to evaluate the drug situation and to prepare an integrated Action Plan aiming at both care provision to crime prevention. In recent years drug use has become a topic of public concern and debate.

## PREVALENCE

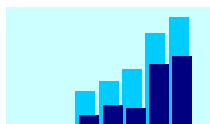
no (recent) data

## TREATMENT

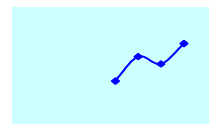
## Treatment demand

First treatment	2982
All treatment	4569
Mean age	
all treatment % < 25	53.9%
first treatment % females	35.5%

First and all treatment



% females



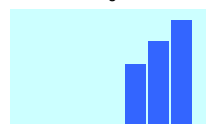
## Opiate substitution

First substitution	156	1997
All substitution	384	1997
Mean age	24.0	1997
all treatment % < 25	71.8%	1997
first treatment % females	32.7%	1997

## Hospital episodes

Psychiatric hospitals	
General hospitals	
Non-fatal emergencies	1626

Non fatal emergencies



## HEALTH

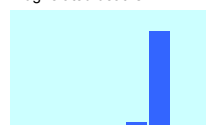
## Injecting drug use

Estimated IDU prevalence	26.0%	1997
reference: all treatment		

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths	207	1997
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## infectious diseases

incidence in IDU

Hepatitis B	4.4%	1997
Hepatitis C	15.6%	1997
HIV	0.0%	1997
Aids	0.0%	1997

% IDU infected

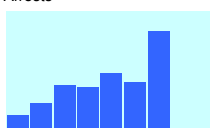
## DRUG LAW OFFENCES

## Arrests for drug law offences

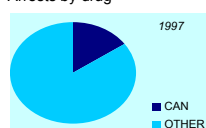
Trafficking	
Consumption	
Total arrests	292

1997

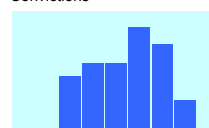
Arrests



Arrests by drug



Convictions



## Convictions for drug law offences

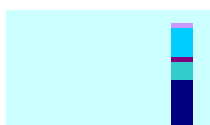
Total convictions	49
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## DRUGS MARKET

## Drug seizures

Cannabis	1283
Heroin	423
Cocaine	132
Amphetamines	720
Ecstasy	123

Number of seizures



**Population:** 488,000 (1997)

### **Geography**

Capital city of Denmark. National and international centre of transport, industry, tourism and culture. Gateway to the other Scandinavian countries. Unemployment: 11.7% (1997) but figures are decreasing. Positive economic development in the 1990s.

### **History and Patterns of drugs use**

In the 1960s recreational use of cannabis and hallucinogens started to spread among young people, first among musicians, artists and other alternative subgroups, in the late 1960s among students. Survey data show that lifetime prevalence of cannabis in 1990 was lower than twenty years before. Cannabis and amphetamine use has been stabilised but there is an overall increase in illicit drug use in the 1990s, in particular of ecstasy and cocaine. The first opiate users were found among the young experimenting generation of the early 1970s but remained limited to small marginalized groups. In the 1970s and 1980s Copenhagen had high figures for drug-related deaths and prevalence of infectious diseases. In the mid-1990s 'chasing the dragon' was introduced as an alternative for injecting heroin. During the 1990s the HIV and AIDS epidemic declined, though Hepatitis C is now widely spread among drug users.

### **Drug interventions and policy**

Since the late 1960s a number of specialised inpatient treatment facilities and projects for social reintegration of drug users were established. Drug prevention projects for schools and special risk groups were initiated in the 1970s and 1980s. In the second half of the 1980s drug treatment and care was expanded by setting up outpatient services, the provision of methadone, the development of outreach services and free delivery of needles and syringes. Many drug users received methadone from GPs, but since 1996 this practice is not allowed anymore.

Drug treatment took place in the social and educational sphere and not in hospitals. In the second half of the 1990s the treatment system became more differentiated, serving many services aimed at various target groups. Since 1997 voluntary treatment in prison was set up. In 1996 general practitioners were not allowed anymore to treat drug users by themselves.

Until the mid-1980s intervention was based on a drug-free treatment strategy. The policy has become more harm reduction oriented since and the treatment system more diversified. The current municipal programme pursues the double aim of a drug free society and harm reduction. In general treatment, prevention and general social care for drug users are seen as more important instruments than police interventions and public prosecution. The city has a co-ordination structure in which local authorities, drug agencies, police and justice are represented.

The Swiss heroin programmes have got a lot of attention in Denmark and provoke an ongoing debate about the national drug policy and the integration of heroin prescription in treatment.



## PREVALENCE

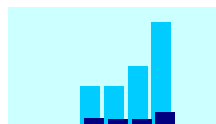
no (recent) data

## TREATMENT

## Treatment demand

First treatment	240	1997
All treatment	1583	1997
first treatment	Mean age	31.7 1997
first treatment	% < 25	20.0% 1997
first treatment	% females	24.0% 1997

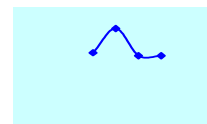
First and all treatment



Mean age and % &lt; 25



% females

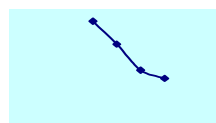


## HEALTH

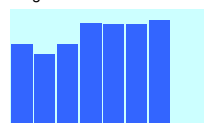
## Injecting drug use

Estimated IDU prevalence	15.0%	1997
reference: all treatment		

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths	73	1997
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## infectious diseases

incidence in IDU

Hepatitis B	5	1997
Hepatitis C		
HIV		
Aids	5	1997

% IDU infected

Incidence in IDU

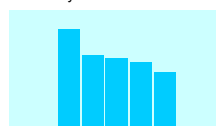


## DRUG LAW OFFENCES

## Arrests for drug law offences

Trafficking	266	1997
Consumption	5609	1997
Total arrests	5875	1997

Arrests by offence



## DRUGS MARKET

no (recent) data

**Population:** 916.000 (1991)

No context information available.

## PREVALENCE

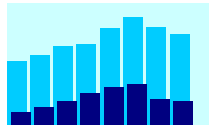
no (recent) data

## TREATMENT

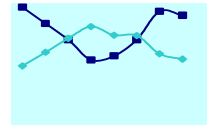
## Treatment demand

	First treatment	871
	All treatment	3357
first treatment	Mean age	21.7
first treatment	% < 25	76.2%
first treatment	% females	32.1%

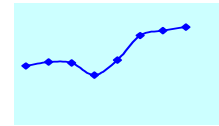
First and all treatment



Mean age and % &lt; 25



% females



## Opiate substitution

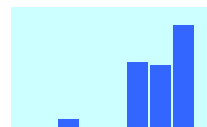
First substitution	
All substitution	3600

## HEALTH

## Injecting drug use

Estimated IDU prevalence	35.3%	1996
reference: all treatment		

Drug related deaths



## Mortality

Drug related deaths	136
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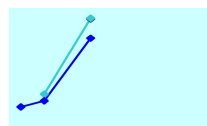
## infectious diseases

incidence in IDU

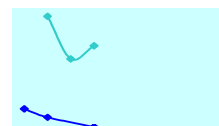
% IDU infected

Hepatitis B	
Hepatitis C	
HIV	
Aids	

Incidence in IDU



% IDU infected

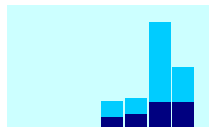


## DRUG LAW OFFENCES

## Arrests for drug law offences

Trafficking	1250
Consumption	1691
Total arrests	2941

Arrests by offence

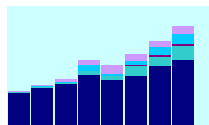


## DRUGS MARKET

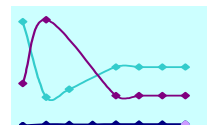
## Drug seizures

Cannabis	4513
Heroin	884
Cocaine	151
Amphetamines	680
Ecstasy	466

Number of seizures



Drug prices



**Population:** 756.000 (1998)

### Geography

Major port city of Poland on the Baltic Sea. Major centre of industry (shipbuilding, chemical industry), commerce, culture and tourism. Positive economic development in the 1990s. Unemployment rate decreased from 13.2% in 1992 to 3.1% in 1997.

### History and Patterns of drugs use

In the late-1960s drug use was observed among subgroups of youngsters using non-prescribed pharmaceutical drugs, cannabis and solvents. It was estimated that during the early 1970s the city counted about 300 problem drug users of pharmaceuticals and/or opiates. In the mid-1970s a new technological development led to the production of 'Polish heroin', which was cheap and relatively easy accessible, and a new wave of users of this illicit substance was observed. Drug use then stabilised between 1985 and 1989. Along with the transition from a 'closed' to an 'open' society in the 1990s, the use of cannabis, inhalants, amphetamines and new drugs such as ecstasy increased among young subpopulations. Cocaine use is relatively rare, but in 1996 the first cocaine users entered the treatment system.

Today, cannabis is the most common illicit drug, followed by amphetamines, LSD, solvents, ecstasy, cocaine and (Polish) heroine. In the general population prevalence of non-prescribed sedatives and tranquillisers comes second after cannabis. The drug problem population predominantly consist of (injecting) users of Kompot or home made 'Polish heroin', who also use other drugs and alcohol. Heroin use seems to stabilise, whereas amphetamine use seems to increase among problem users. Since 1997 the introduction of 'brown sugar' or 'brown powder', the smoking of heroin in a cigarette, not uncommonly mixed with marihuana, is observed in clubs among young subgroups.

### Drug interventions and policy

Until 1980 the drug problem did officially not exist in Poland. The first treatment centres in the city –the Drug Rehabilitation Centre and an outpatient clinic for drug users– were established in 1981. A number of (specialised) inpatient and outpatient treatment facilities have been established in the city since, including clinics for HIV/AIDS patients, a majority of them being drug users. Drug users in treatment undergo detoxification in the Psychiatric Hospital before being accepted to one of the residential centres. In the late-1980s and the 1990s several other medium-/high-threshold programmes for drug users were initiated in the city: rehabilitation programme for drug users in prison (1986), a syringe and needle exchange programme (1989), drug prevention projects aiming at the general public, specific risk groups, schools, workplaces, support programmes for families of drug users and HIV-infected users, outreach services, etc.

At local level the drug policy is coordinated by the Gdansk Advisory Council. The Council defines drug strategies in which all levels of governmental and non-governmental organisations work effectively together to reduce harm associated with the use of illicit drugs.

The police combat drug-related crime at several levels. At the level of city districts they concentrate on small and medium-level dealing, drug use and other crimes. At city level the Gdansk District Command of Police deals with major drug trafficking. Customs and the Prison Anti-Drug Division control respectively the port and airport and the city prison.

In 1997 the Polish Parliament adopted the Law on Strategies to Counteract Drug Dependence to replace the law on the prevention of drug dependence of 1985. The new law provides the legal grounds for taking more decisive action to reduce the supply and demand of illicit drugs, similar to the legal regulations implemented in other European countries, and balances prevention and treatment with severe penalties of drug-related offences. Drug users can be compulsory send to treatment centres for rehabilitation. The philosophy behind this is not to force users with rules or requirements, but to establish conditions in which the individual will develop his/her personality and to maintain a place in society. A recent initiative in Gdansk drug policy is the incorporation of drug treatment in open health care structures.

## PREVALENCE

## Cannabis use

Ever (LTP)  
Recent (LYP)  
Current (LMP)

general population

school population

8.7% 1997

Cannabis prevalence

Problem drug users

## Problem drug use

Prevalence estimate 2630

## TREATMENT

## Treatment demand

First treatment 366  
All treatment 1323

first treatment Mean age 18.7  
first treatment % < 25 98.6%  
first treatment % females 25.7%

First and all treatment

Mean age and % &lt; 25

% females

## Hospital episodes

Psychiatric hospitals  
General hospitals  
Non-fatal emergencies 598

Non fatal emergencies

## HEALTH

## Injecting drug use

Estimated IDU prevalence 96.2%  
reference unknown

Prevalence of IDU

Drug related deaths

## Mortality

Drug related deaths 46

## infectious diseases

incidence in IDU

Hepatitis B 31  
Hepatitis C 38  
HIV 235  
Aids 10

% IDU infected

34.0%  
38.0%  
32.0%  
0.8%

Incidence in IDU

% IDU infected

## DRUG LAW OFFENCES

## Arrests for drug law offences

Trafficking 39  
Consumption 109  
Total arrests 191

Arrests by offence

Arrests by drug

Convictions

## Convictions for drug law offences

Total convictions 64

## DRUGS MARKET

## Drug seizures

Cannabis 428  
Heroin 371  
Cocaine 5  
Amphetamines 37  
Ecstasy 17

Number of seizures

Drug prices

**Population:** 401.000 (1997)

### **Geography**

Located in the French speaking area of Switzerland on the French border. International city. 40% of the population is of foreign origin. Geneva is the seat of several UN institutions and other international organisations. Important financial centre. Unemployment rate: 6.8% (1996).

### **History and Patterns of drugs use**

Drugs (cannabis, opiates) first appeared in the city in the 1970s. Drug use increased in the 1980s, in particular the use of heroin. Injecting became the common route of heroin administration.

### **Drug interventions and policy**

Until the mid-1980s police interventions were the main response of the city to the drug problem. From the end of the 1980s however emerged a medicalisation of the drug problem due to the health risk associated with intravenous drug use. Following extensive political and public debates about intervention approaches, in particular after the city of Zurich closed its "open drug scene", a diversified system of treatment and care facilities has been established. This includes methadone substitution and participation in the Swiss programme of controlled prescription of heroin.

## PREVALENCE

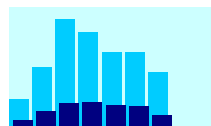
no (recent) data

## TREATMENT

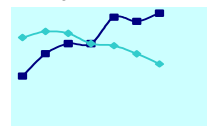
## Treatment demand

	First treatment	160	1997
	All treatment	656	1997
first treatment	Mean age	27.7	1997
first treatment	% < 25	32.0%	1997
first treatment	% females	15.0%	1997

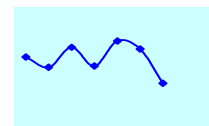
First and all treatment



Mean age and % &lt; 25



% females

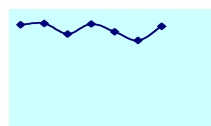


## HEALTH

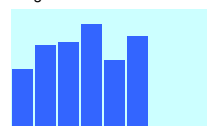
## Injecting drug use

Estimated IDU prevalence	34.4%	1997
reference: first treatment		

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths	31	1996
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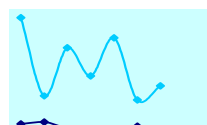
## Infectious diseases

incidence in IDU

Hepatitis B	1	1997
Hepatitis C		
HIV		
Aids	22	1997

% IDU infected

Incidence in IDU

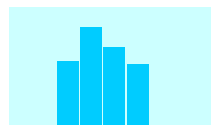


## DRUG LAW OFFENCES

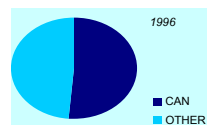
## Arrests for drug law offences

Trafficking	78	1996
Consumption	1752	1996
Total arrests	1830	1996

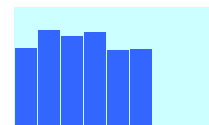
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

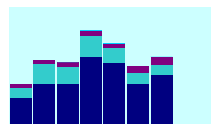
Total convictions	393	1996
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## DRUGS MARKET

## Drug seizures

Cannabis	1330	1997
Heroin	250	1997
Cocaine	189	1997
Amphetamines	3	1997
Ecstasy		

Number of seizures



**Population:** 1.708.000 (1996)

### **Geography**

Main seaport of Germany located near the North Sea at the river Elbe. Unemployment about 13% in 1997. Cultural centre with a tradition of active alternative subcultures.

### **History and Patterns of drugs use**

After a peak of the incidence of heroin users in the early 1990s, it seems that their number is stabilising or possibly decreasing. Until 1995 the total number of heroin/problem drug users in the city was officially estimated at 10000 (which is probably an overestimation), in subsequent years this number decreased. In 1997 the size of the population of problem drug users is estimated between 7000 and 8000. They are predominantly intravenous heroin users.

In the 1990s cannabis use became widespread among young adults, while the new drug ecstasy, often associated with juvenile 'rave' and 'techno' dance scenes, has become the second popular illicit drug. Cocaine use appears to rise since 1995 among drug users on the street as well as among 'non-deviant' subpopulations.

### **Drug interventions and policy**

Hamburg has a wide variety of intervention structures, including several low-threshold centres and programmes. Needle exchange programmes and methadone substitution are available since 1995.

The Hamburg drug policy is harm reduction oriented. Criminal prosecution is mainly directed at trafficking. In the 1990s visible drug markets ("open scenes") at the central railway station, in park areas and specific districts caused major public concern and debate about drug related nuisance and intervention strategies.



## PREVALENCE

## Problem drug use

Prevalence estimate 7500 1997

## TREATMENT

## Treatment demand

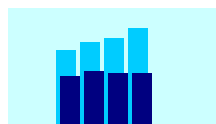
First treatment 2795 1996  
All treatment 5013 1996

Mean age

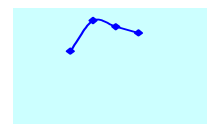
% < 25

first treatment % females 32.0% 1996

First and all treatment



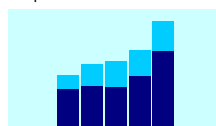
% females



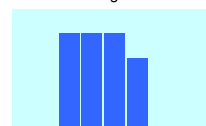
## Hospital episodes

Psychiatric hospitals 1324 1997  
General hospitals 487 1997  
Non-fatal emergencies 1500 1996

Hospital admissions



Non fatal emergencies

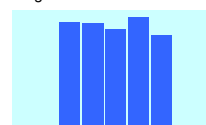


## HEALTH

## Injecting drug use

Estimated IDU prevalence 90.0% 1996  
reference: all treatment

Drug related deaths



## Mortality

Drug related deaths 127 1997

## infectious diseases

incidence in IDU

% IDU infected

Hepatitis B

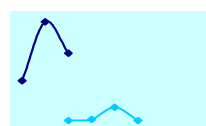
Hepatitis C

HIV

Aids

9 1996

Incidence in IDU

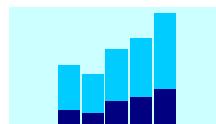


## DRUG LAW OFFENCES

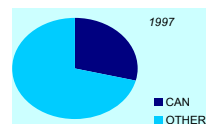
## Arrests for drug law offences

Trafficking 4584 1997  
Consumption 8657 1997  
Total arrests 13241 1997

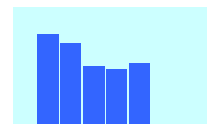
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

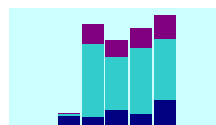
Total convictions 1354 1996

## DRUGS MARKET

## Drug seizures

Cannabis 740 1997  
Heroin 1505 1997  
Cocaine 566 1997  
Amphetamines  
Ecstasy

Number of seizures



**Population:** 539.000 (1998)

### **Geography**

Capital of Finland. National centre of commerce and industry.

### **History and Patterns of drugs use**

Traditionally illicit drugs are much less used than other intoxicants like alcohol and medicines. In the early 1990s only 1% of services dealing with dependency problems concerned drug related problems. Drug use might have increased since but known figures partly reflect more intensified police control following the revision of the Narcotics Act in 1994. Cannabis is the most common illicit drug used among the general and school population. Compared to cannabis use, the use of other illicit drugs is relatively low. The intoxicant use of barbiturates and sedatives, in particular in combination with alcohol, is a more common problem. Surveys data show that illicit drug use is much higher in Helsinki than elsewhere in Finland.

### **Drug interventions and policy**

Treatment services in Finland are for a large part oriented to alcohol abuse or the mixed use of alcohol and medicines. Since 1987, the Drug Withdrawal Unit of the Helsinki University Central Hospital is the only facility specialised in treatment of drug users within the health care system. The Narcotics Act of 1994 implied some decrease in the penalisation of use-related offences, but drug use as such continued to be a punishable act. Police investigations on drug-related offences have intensified since. The national programme initiated by the Ministry of Social Affairs and Health includes elements of harm reduction, but the focus remains on repressive control at street level. No changes in the current legislation are foreseen.

PREVALENCE

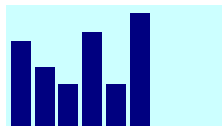
no (recent) data

TREATMENT

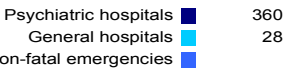
Treatment demand



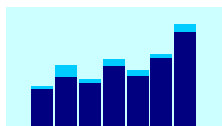
First and all treatment



Hospital episodes

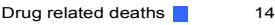


Hospital admissions

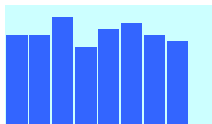


HEALTH

Mortality



Drug related deaths

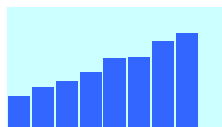


DRUG LAW OFFENCES

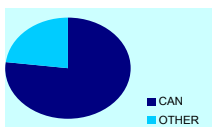
Arrests for drug law offences



Arrests



Arrests by drug



DRUGS MARKET

no (recent) data

**Population:** 421.000 (1996)

### **Geography**

Kaliningrad is a big non-freezing port, linked with the Baltic see by means of a deep canal. It serves as the base of a large fishing and transport fleet. The region of Kaliningrad, bordered by Lithuania and Poland is isolated from the rest of the territory of Russia. In recent years the population has increased due to migration, but natural growth is negative with death rates exceeding birth rates and a decrease of general life expectancy.

### **History and Patterns of drugs use**

Since the mid 1990s heroin is replacing homemade opiates in the local drug market. Kaliningrad has the highest prevalence of HIV infection of all Russia. HIV was first observed in 1996 but spread rapidly since, mainly due to transfer of the virus through sharing needles to inject drugs, though an exact figure cannot be provided. On the other hand incidence of Hepatitis B and drug related mortality decreased.

### **Drug interventions and policy**

Drug related emergencies decreased in recent years. Treatment demand remained stable of the past years. Police arrests also decreased. There are no signals however that trends in these data indicate a decrease in drug consumption.

## PREVALENCE

no (recent) data

## TREATMENT

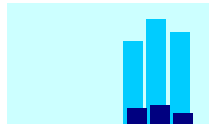
## Treatment demand

	First treatment	<div></div>	190
	All treatment	<div></div>	1517
first treatment	Mean age	<div></div>	25.7
first treatment	% < 25	<div></div>	37.8%
first treatment	% females	<div></div>	20.5%

## Hospital episodes

Psychiatric hospitals	42
General hospitals	
Non-fatal emergencies	31

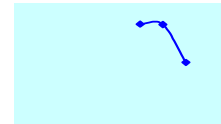
First and all treatment



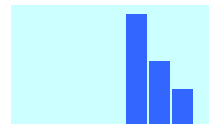
Mean age and % &lt; 25



% females



Non fatal emergencies



## HEALTH

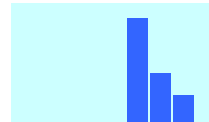
## Injecting drug use

Estimated IDU prevalence	86.6%	1997
reference:	all treatment	

## Mortality

Drug related deaths	12
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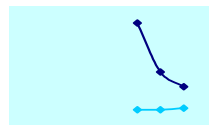
Drug related deaths



## infectious diseases

	incidence in IDU	% IDU infected
Hepatitis B	27	
Hepatitis C		
HIV		
Aids	2	

Incidence in IDU

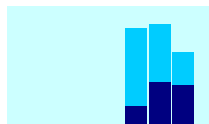


## DRUG LAW OFFENCES

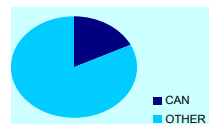
## Arrests for drug law offences

Trafficking	627
Consumption	481
Total arrests	1108

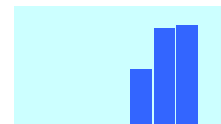
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

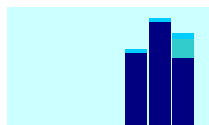
Total convictions	503
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## DRUGS MARKET

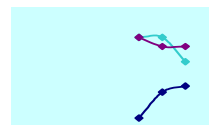
## Drug seizures

Cannabis	234
Heroin	60
Cocaine	
Amphetamines	20
Ecstasy	

Number of seizures



Drug prices



**Population:** 480.000 (1998)

### **Geography**

Kemerovo is situated in the southern part of Western Siberia. It is a regional industrial centre with chemical, oil-chemical, power and metallurgical industries. The area has both declining and growing industries. There is a considerable shortage of proper housing. The city received in the 1990s many migrants, displaced persons from former Central Asia Soviet republics. At the same time many inhabitants left the city adding to the general picture of demographic transition.

### **History and Patterns of drugs use**

From the end of 1970s opiates and cannabis derivatives began to be brought into Kemerovo from Kirgizia and Kazakhstan. Drug trafficking is mainly carried out by residents of former Central Asia Soviet republics. On the market opiates, cannabis derivatives, and ecstasy (and look-alikes) prevail. Heroin use is increasing and in general availability of all drugs has increased.

### **Drug interventions and policy**

The city operates several specialised drug services. Non-governmental organisations and private practitioners also provide treatment and care, they are not covered by official statistics however. Drug policy is implemented by the Regional and City Health Departments. The Kemerovo region also has a coordination council for the struggle against drug addiction that involves all domains.

## PREVALENCE

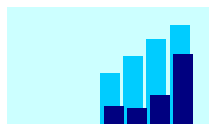
no (recent) data

## TREATMENT

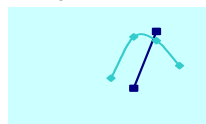
## Treatment demand

First treatment		854	
All treatment		1192	
first treatment	Mean age	20.7	1997
first treatment	% < 25	51.9%	
first treatment	% females	23.2%	

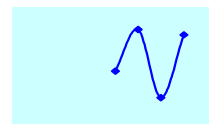
First and all treatment



Mean age and % &lt; 25



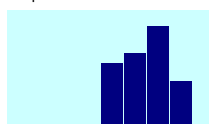
% females



## Hospital episodes

Psychiatric hospitals	418
General hospitals	
Non-fatal emergencies	514

Hospital admissions

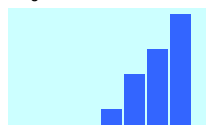


## HEALTH

## Mortality

Drug related deaths	76
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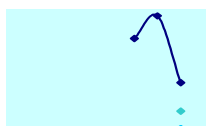
Drug related deaths



## infectious diseases

	incidence in IDU	% IDU infected
Hepatitis B	197	
Hepatitis C	78	
HIV		
Aids	7	

Incidence in IDU

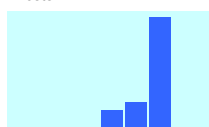


## DRUG LAW OFFENCES

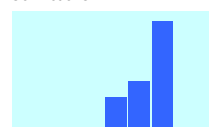
## Arrests for drug law offences

Trafficking	
Consumption	
Total arrests	1137

Arrests



Convictions



## Convictions for drug law offences

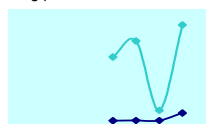
Total convictions	549
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## DRUGS MARKET

## Drug seizures

Cannabis	
Heroin	
Cocaine	
Amphetamines	
Ecstasy	

Drug prices



**Population:** 768.000 (1996)

### **Geography**

Situated in the South of Russia near the border with Georgia. In the 1990s Krasnodar has obtained a frontier zone status with several territories of the former USSR. Military activities in these regions (Georgia, Armenia, Chechnya) resulted in large numbers of migrants from these regions, which are not accounted for in official statistics. The actual population might at present exceed 1 million. The official demographic figures show similar trends as elsewhere in Russia: decreasing birth rates, increasing infant mortality and increased general mortality.

### **History and Patterns of drugs use**

The use of all sorts of drugs increased in the 1990s. Frontier position, instable demographic situation and the refugee problem all favour the increase of drug use and related problems. In recent years trends remain partly hidden as dependent users tend to seek help from private clinics (established since 1992), which are not covered by local statistics. Illegal drugs can easily enter the region from neighbouring countries. Many drugs are being delivered through seaports of the Kuban province (Novorossijk, Sochi, Tuapse). Cannabis is also grown locally. Besides police confiscations indicate an increase of half-synthetic and synthetic preparations such as pervitin, methadone, MDMA, LCD etc. Administration of homemade opium in syringes is one of the main channels of the spreading of HIV-infection among addicts.

### **Drug interventions and policy**

Treatment demands increased in the early 1990s, but remained relatively stable in later years. This is connected with the diversion of drug users to private clinics, where they are not registered. The number of admissions into specialised psychiatric hospitals increased but admissions to general hospitals have decreased. The latter might also be caused by errors in diagnostics. At regional level in 1998 a coordinated programme to counter abuse of drugs and illegal trafficking has been approved.



## PREVALENCE

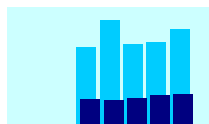
no (recent) data

## TREATMENT

## Treatment demand

	First treatment	1980	
	All treatment	5734	
first treatment	Mean age	22.2	1997
first treatment	% < 25	51.2%	
first treatment	% females	12.3%	

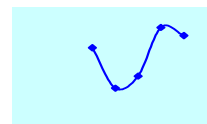
First and all treatment



Mean age and % &lt; 25



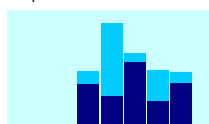
% females



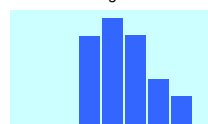
## Hospital episodes

Psychiatric hospitals	805
General hospitals	168
Non-fatal emergencies	409

Hospital admissions



Non fatal emergencies



## HEALTH

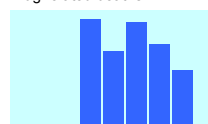
## Injecting drug use

Estimated IDU prevalence	85.0%
reference: first treatment	

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths	35
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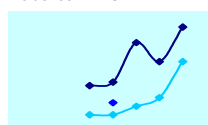
## infectious diseases

incidence in IDU

Hepatitis B	51
Hepatitis C	
HIV	
Aids	31

% IDU infected

Incidence in IDU

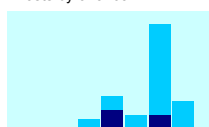


## DRUG LAW OFFENCES

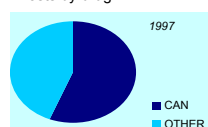
## Arrests for drug law offences

Trafficking	121
Consumption	1675
Total arrests	1796

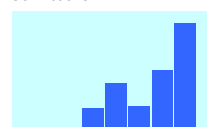
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

Total convictions	1796
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## DRUGS MARKET

no (recent) data

**Population:** 1.836.000 (1991)

### **Geography**

Capital city of Portugal. Main centre of transport, commerce, industry and culture. In 1997 the unemployment rate was 7%.

### **History and Patterns of drugs use**

From the mid-1970s till the mid-1980s illicit drug use was limited to cannabis. From the mid-1980s onwards there has been a sharp increase in heroin use. In recent years the number of heroin users seem to be stabilise, while cocaine use became the second problem drug. In the late 1990s both the use and availability of ecstasy and amphetamines increase as well. The increase in treatment demand is related to the growth of both the number of problem users and treatment facilities. In the 1990s cannabis use as well as the use of new drugs such as ecstasy and amphetamines increased.

### **Drug interventions and policy**




In the mid-1970s the first specialised drug treatment and primary prevention service was established in the city. In the 1990s the number of treatment facilities and programmes has expanded, now including day-centres for drug users, treatment facilities in prison and AIDS prevention programmes. Needle exchange is available since 1993. In 1994 the first methadone maintenance programmes were established. In 1997 the national government expanded the network of the state-operated Centres for Drug Treatment throughout the country and improved support to private organisations to increase activities on prevention and treatment. The state centres are more targeted on outpatient treatment, whereas the private ones are more targeted to inpatient treatment. Psychotherapy and socio-therapy are the main treatment approaches.

In 1998 the national government appointed a Commission of Experts to propose a national strategy to combat illicit drugs. Local drug policies focus mainly on primary prevention.

Since the 1970s drug use is seen as a major medical and psychosocial problem. Intervention focuses both on law enforcement and on the availability of (voluntary) treatment and (primary) prevention. At present depenalisation of the use and possession (for personal use) of drugs and the expansion of substitution maintenance programmes are topics of public and policy debate.

## PREVALENCE

## Cannabis use

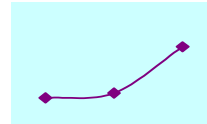
Ever (LTP)   
Recent (LYP)   
Current (LMP) 

general population

school population

6.3%




Cannabis prevalence



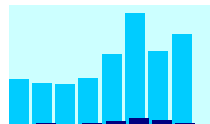
## TREATMENT

## Treatment demand

First treatment  2173  
All treatment  53192


Mean age   
% < 25   
% females 

First and all treatment

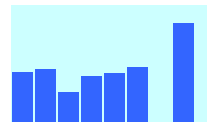


## HEALTH





## Mortality

Drug related deaths  212

Drug related deaths



## infectious diseases

Hepatitis B   
Hepatitis C   
HIV   
Aids 

incidence in IDU

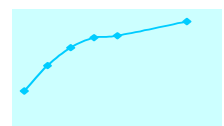
% IDU infected

63.2%

Incidence in IDU



% IDU infected

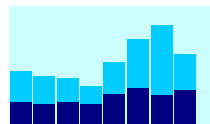


## DRUG LAW OFFENCES

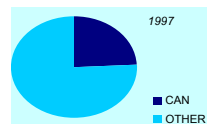
## Arrests for drug law offences

Trafficking  1062  
Consumption  1033  
Total arrests  2095

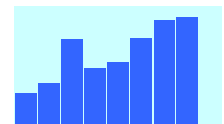
Arrests by offence




Arrests by drug



Convictions



## Convictions for drug law offences

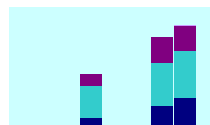
Total convictions  1083

## DRUGS MARKET

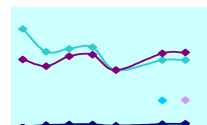
## Drug seizures

Cannabis  630  
Heroin  967  
Cocaine  510  
Amphetamines  0  
Ecstasy  13

Number of seizures



Drug prices



**Population:** 288.000 (1997)

### **Geography**

Capital of Slovenia. National centre of finance, trade, transport and industry. Unemployment rapidly increased since late 1980s, in 1997: 10.8%.

### **History and Patterns of drugs use**

From the late 1960s to the mid-1970s solvents, cannabis, LSD, tranquillisers and painkillers were popular among a few 'alternative' groups. In this period there was limited experimentation with heroin. Injecting drug use was rare. In the late 1970s, small 'deviant' groups started to inject opiates. Since the late 1980s the incidence and prevalence of (injection) heroin use increased, while the average age of the heroin-using population decreased. Cocaine has been introduced among a considerable number of drug users in the early 1990s. In the mid-1990s ecstasy became popular among young people. Today the main illicit drugs used are cannabis, LSD, ecstasy, heroin, cocaine and amphetamines. School surveys indicate that sedatives are more common among youngsters than any illicit drug other than cannabis.

### **Drug interventions and policy**

Ljubljana has 12 specialised treatment centres, ranging from psychiatric and non-psychiatric hospitals, day-care treatment centres to therapeutic communities. Inpatient facilities provide detoxification and drug-free rehabilitation programmes. A non-residential methadone substitution programme started in 1991. The self-help organisation Stigma operates a needle exchange programme. Centres for Social Work provide social care and organise prevention programmes. Local drug policy coincides with national policy. Since 1992 operates an Inter-ministerial Committee for Fight against Drugs which is responsible for defining policies and coordinates interventions. The policy is based on harm reduction. Treatment centres cooperate in a Health Service Network. The Ministry of Health is involved in the preparation of new legislation on the classification and regulation of the cultivation, production and trade of illicit psychotropic substances and precursors. In the penal system the use of illicit drugs is not penalised. Possession of small quantities of drugs is a petty offence.

## PREVALENCE

## Problem drug use

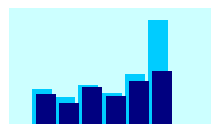
Prevalence estimate 700 1997

## TREATMENT

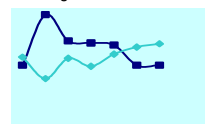
## Treatment demand

First treatment	145	1997
All treatment	270	1997
first treatment	Mean age	23.2 1997
first treatment	% < 25	71.0% 1997
first treatment	% females	24.0% 1997

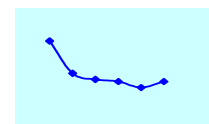
First and all treatment



Mean age and % &lt; 25



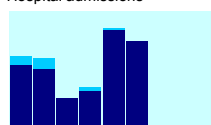
% females



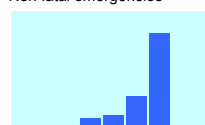
## Hospital episodes

Psychiatric hospitals	45	1996
General hospitals	0	1996
Non-fatal emergencies	98	1997

Hospital admissions



Non fatal emergencies

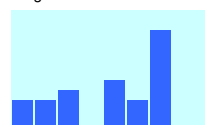


## HEALTH

## Mortality

Drug related deaths 10 1997

Drug related deaths



## infectious diseases

Hepatitis B	0	1996
Hepatitis C		
HIV		
Aids	2	1997

incidence in IDU

% IDU infected

Incidence in IDU

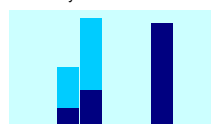


## DRUG LAW OFFENCES

## Arrests for drug law offences

Trafficking	223	1997
Consumption		
Total arrests		

Arrests by offence



## DRUGS MARKET

no (recent) data

**Population:** 378.000 (1995)

### **Geography**

Malta is an island state situated in the middle of the Mediterranean Sea, sixty miles south off Sicily. Valletta is the capital and major port. The economy mainly relies on tourism (1 million visitors each year), to some extent supported by small and medium industries. The 1990s have resulted in the development of a service and financial sector. Unemployment rate: 5.1% (1998).

### **History and Patterns of drug use**

The appearance of drug use among young adults can probably be ascertained to have taken its roots during the early to mid 1970s. At that time this phenomenon was mainly related to the use of pharmaceutical products such as tranquillisers (anxiolytics), sleeping pills, dieting and codeine preparations along with cannabis smoking and inhalants within a limited cohort. Such behaviour may be mainly attributed to the Malta-London link. During the 1980s intravenous heroin use had also made its presence felt. The early 1990s were really punctuated by a rapid increase in the use of a number of drugs that coincided with the relatively new found wealth within the country. Drug use was now out in the open and to this day features prominently within the media, be it newspapers, radio or television. The turn of the century has been marked by an increase in stimulant use, most notably ecstasy.

### **Drug interventions and policy**

The treatment for drug use in the early 1980s was entirely the domain of health professionals and as such confined to psychiatrists operating from the only mental hospital on the Island. In 1985 however Caritas Malta opened a rehabilitation centre and in 1987 the Government opened an outpatient detoxification unit (methadone & clonidine) within the grounds of the national general hospital. An inpatient unit soon followed in 1989. The Government rehabilitation unit was opened in 1992; and 1994 heralded the arrival of the National Drug Agency (Sedqa), which took responsibility for the three Government units. Sedqa has since developed community based programmes, a prison based facility and an extensive prevention programme in schools. Recent developments include maintenance therapy (methadone), the introduction of naltrexone and an accompanying programme (Stima), a needle distribution system through the health centres and a secondary prevention unit.

In the field of jurisdiction, Malta has acceded to the 1988 United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances. A bill has also been passed through parliament to include psychotropics as well as the conventional narcotics.

In 1994, The Prevention of Money Laundering Act was passed. In the same year the Dangerous Drug Ordinance of 1939 was also amended to include coerced treatment and a more complete definition of a trafficking offence. These positive changes in the law following those of 1986, in which stiffer penalties for drug traffickers were introduced along with the freezing and forfeiture of assets, are a serious attempt to limit illicit trafficking and are fully supported by the public at large.

## PREVALENCE

## Cannabis use

	general population	school population
Ever (LTP)		7.0%
Recent (LYP)		5.1%
Current (LMP)		2.7%

## Problem drug use

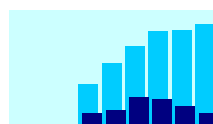
Prevalence estimate	3700	1997
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## TREATMENT

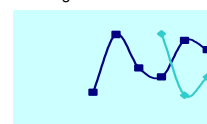
## Treatment demand

First treatment	134	1999
All treatment	797	1999
first treatment Mean age	24.7	1999
first treatment % < 25	59.0%	1999
first treatment % females	16.0%	1999

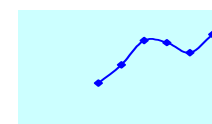
First and all treatment



Mean age and % &lt; 25



% females



## Opiate substitution

First substitution	239	1997
All substitution	741	1997
Mean age		
first treatment % < 25	66.1%	1997
first treatment % females	14.6%	1997

## Hospital episodes

Psychiatric hospitals		
General hospitals		
Non-fatal emergencies	132	1999

Non fatal emergencies



## HEALTH

## Injecting drug use

Estimated IDU prevalence	6.0%	1997
reference: first treatment		

Drug related deaths



## Mortality

Drug related deaths	8	1999
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## infectious diseases

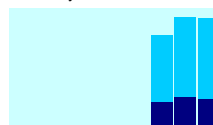
	incidence in IDU	% IDU infected
Hepatitis B	2	1.8%
Hepatitis C	48	8.7%
HIV	0	0.0%
Aids	0	0.0%

## DRUG LAW OFFENCES

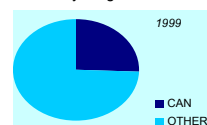
## Arrests for drug law offences

Trafficking	129	1999
Consumption	333	1999
Total arrests	462	1999

Arrests by offence



Arrests by drug

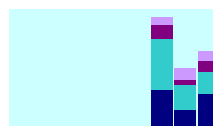


## DRUGS MARKET

## Drug seizures

Cannabis	94	1999
Heroin	52	1999
Cocaine	27	1999
Amphetamines	0	1999
Ecstasy	24	1999

Number of seizures



**Population:** 8.630.000 (1998)

### **Geography**

Capital of the Russian Federation. One of the biggest European metropolitan areas. Situated in the centre of the European part of Russia. Transport junction with 5 airports, 7 railway stations, 2 river ports. Moscow has a diversified industry. Centre of government and commercial services. In recent years decrease in industrial production and investment and increase in social problems. Demographic characteristics: aging population, negative natural increase, decreasing number of permanent residents, increasing number of immigrants. Moscow is the seat of the Russian Academy of Sciences, the Academy of Medical Sciences, many scientific research institutions, more than 100 higher educational institutions. It is also a major centre of cultural life.

### **History and Patterns of drugs use**

For a long time the use of drugs and other psychoactive substances in Moscow was considerably less than in Russia on the whole. Apparent drug use –as indicated by first treatment demands–increased after the 1985 repressive anti-alcohol legislation. Not only because of increasing use but also because the anti-alcohol campaign had promoted a broadening of the network of institutions that provide treatment and care for addictions in general. At present the level of drug use in Moscow exceeds the average for Russia. Among drug users the persons of younger age prevail, the rate of female users continues to grow. Indices of drug related morbidity and mortality are increasing. Saturation of the illegal market with drugs and their wide availability are seen as the main causes of the sharp increase of use. Drug injecting also increases.

### **Drug interventions and policy**

Moscow has 2 day-and-night hospitals and 11 day-hospitals for addiction treatment. Besides treatment can be provided in psychiatric hospitals and toxicology departments of general hospitals.



## PREVALENCE

## Cannabis use

Ever (LTP)  
Recent (LYP)  
Current (LMP)

general population

school population

3.5% 1999

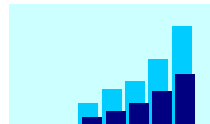
## TREATMENT

## Treatment demand

First treatment 10617  
All treatment 20371

Mean age  
first treatment % < 25 27.9% 1997  
first treatment % females 18.5%

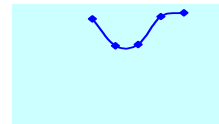
First and all treatment



Mean age and % &lt; 25



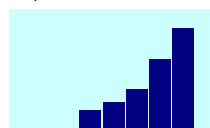
% females



## Hospital episodes

Psychiatric hospitals 10077  
General hospitals  
Non-fatal emergencies

Hospital admissions

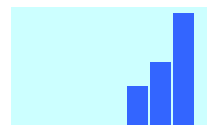


## HEALTH

## Mortality

Drug related deaths 285

Drug related deaths



## infectious diseases

incidence in IDU

% IDU infected

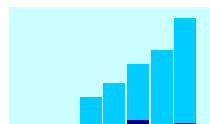
Hepatitis B  
Hepatitis C 1842  
HIV  
Aids 17

## DRUG LAW OFFENCES

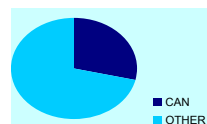
## Arrests for drug law offences

Trafficking 482  
Consumption 7687  
Total arrests 8169

Arrests by offence



Arrests by drug

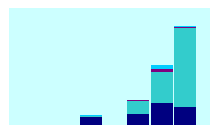


## DRUGS MARKET

## Drug seizures

Cannabis 1720  
Heroin 5823  
Cocaine 76  
Amphetamines 61  
Ecstasy

Number of seizures



**Population:** 1.399.000 (1998)

### **Geography**

Major town in Western Siberia on the river Ob. Important transport junction. Heavy industries, large military industrial complex, several scientific-research institutions. Demographic features: growth of mortality, lowering of birth rate, many citizens of foreign origin, persons without citizenship and displaced persons from areas with traditional drug use. High level of unemployment in connection with the reduction of production outputs, worsening of socio-economical situation.

### **History and Patterns of drugs use**

Drug use is widespread. There is a great variety of drugs on the market and availability is increasing. Opiates, cannabis, cocaine, amphetamines and ephedron prevail. According to data of school surveys, near 15% of school pupils use drugs; among first-year students of high schools prevalence of any drug is near 20%. Intravenous injection of drugs is practiced by over 80% of addicts.

Increase of drug use among young people is observed. Heroin and methadone increasingly replace other opiate products. Intranasal use of heroin is spreading. Continued upward trends of drug use and drug related problems are expected.

### **Drug interventions and policy**

A wide range of treatment and care facilities have been established, in particular since 1995. Demands for treatment and care for drug related diseases and emergencies increase. Recently a new local programme on prevention of addictions among youngsters has been approved. There is a confidential telephone help-line for drug problems and there are active social organisations of parents against drugs. Novosibirsk has an inter-sectorial coordinating body involving all domains in drug intervention.

## PREVALENCE

no (recent) data

## TREATMENT

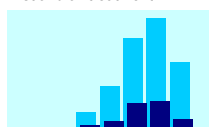
## Treatment demand

First treatment	1023
All treatment	5697
Mean age	
first treatment % < 25	13.4%
first treatment % females	15.1%

## Hospital episodes

Psychiatric hospitals	700
General hospitals	383
Non-fatal emergencies	413

## First and all treatment



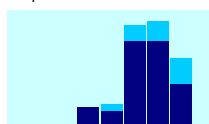
## Mean age and % &lt; 25



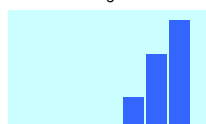
## % females



## Hospital admissions



## Non fatal emergencies



## HEALTH

## Injecting drug use

Estimated IDU prevalence	83.0%
reference: all treatment	

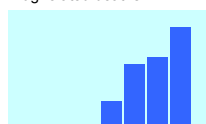
## Mortality

Drug related deaths	77
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## Prevalence of IDU



## Drug related deaths



## infectious diseases

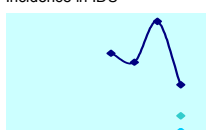
incidence in IDU

Hepatitis B	327
Hepatitis C	121
HIV	
Aids	18

## % IDU infected

0.5% 1997

## Incidence in IDU

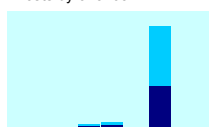


## DRUG LAW OFFENCES

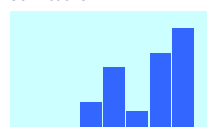
## Arrests for drug law offences

Trafficking	1163	1997
Consumption	1459	1997
Total arrests	4900	

## Arrests by offence



## Convictions



## Convictions for drug law offences

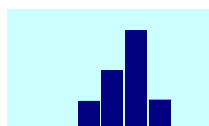
Total convictions	3413
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## DRUGS MARKET

## Drug seizures

Cannabis	879	1997
Heroin	4	1997
Cocaine	2	1997
Amphetamines	1	1997
Ecstasy		

## Number of seizures



## Drug prices



**Population:** 527.000 (1998)

### **Geography**

The town is situated in the Southern Ural region at the southern boundary of the central part of Russia, at border with Kazakhstan where Europe meets Asia. It's a junction of transport communications between Russia and Central Asian countries. The town has a relatively young population. Persons aged less than 30, make 43% of the total. Socio-demographic situation is characterized by a decrease of natality, increase of mortality and an increase of the flow of displaced persons from the ex-USSR countries. Forced migration into the Orenburg region is caused by the political and socio-economical changes and the worsening of inter-nations relations in the former USSR countries in the last decade. As much as 68.000 refugees were officially registered in the Orenburg region in the period 1992–1998. The majority of these forced migrants are Russians. At the same time there is also substantial emigration from the region, in recent years emigration has exceeded immigration. Overall, the demographic situation in the last decade has been quite unstable, which affects the social fabric of the city.

Historically, the population of the city is multinational. Russians prevail, but there are Tatars, Bashkirs, Kazakhs, Tadjiks, Ukrainians, Germans, etc. as well. In recent years inter-nation tension was growing.

Due to its advantageous geographical position Orenburg is a big industrial centre of the Ural economic region. It's a multi-profile industrial conglomeration, where branches of heavy, light and food industries are combined. The production of the Orenburg gas complex is exported to many regions of Russia and abroad. Following the privatisation of state enterprises the economic situation has worsened. There are an increasing number of unprofitable enterprises (42% according to 1996 data). The volume of industrial production decreases. Combined with the general monetary crisis in Russia standards of living are continuously falling down.

### **History and Patterns of drugs use**

According to official statistical data, the rate of individuals, taken on register due to systematic abuse of psychoactive substances was 17-18 per 100,000 in the mid 1980s. It increased slowly to up to 37 in 1995. But in the last 3 years the rate has increased very quickly and in 1998 it reached 305. Results of special investigations indicate that use of drugs, especially opiates, in the mass of the population spreads quickly. If in the beginning of 1990s drug users had usually been unemployed individuals with a criminal past or affiliation, but in the last 2-3 years drug use spread among students of higher education institutions and into middle and higher social classes of the population.

During the last decade the range of drugs consumed has also changed. In 1997 heroin appeared on the Orenburg market and from mid-1998 it began to spread swiftly. Users switched from homemade opiates made of poppy straw first to the solution of raw opium and later to heroin. Since 1997 also cocaine, LSD and ecstasy came on the market. The changes also led to increased intravenous drug use and an increase in associated health problems.

### **Drug interventions and policy**

Following increased prevalence, treatment demand and drug related medical interventions increased substantially. Most are related to heroin use. In the 1990s service provision has been diversified to cope with increasing drug use and drug related problems.

There is a coordinating body at regional level for development and evaluation of intervention strategies, including representatives of all relevant domains.

## PREVALENCE

no (recent) data

## TREATMENT

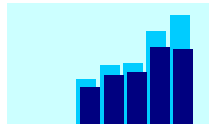
## Treatment demand

	First treatment	<div></div>	624
	All treatment	<div></div>	900
first treatment	Mean age	<div></div>	22.2
first treatment	% < 25	<div></div>	73.6%
first treatment	% females	<div></div>	6.1%

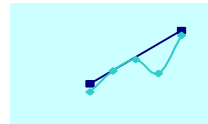
## Hospital episodes

Psychiatric hospitals	134
General hospitals	52
Non-fatal emergencies	627

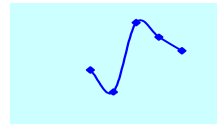
First and all treatment



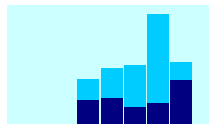
Mean age and % &lt; 25



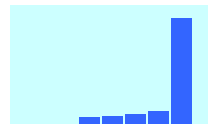
% females



Hospital admissions



Non fatal emergencies



## HEALTH

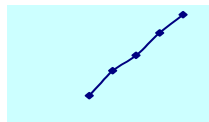
## Injecting drug use

Estimated IDU prevalence	83.0%
reference: all treatment	

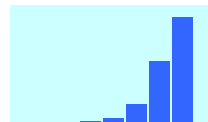
## Mortality

Drug related deaths	45
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Prevalence of IDU



Drug related deaths



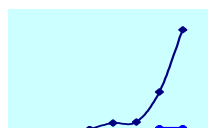
## infectious diseases

	incidence in IDU
Hepatitis B	100
Hepatitis C	
HIV	2
Aids	

% IDU infected

7.7%
0.2%

Incidence in IDU



## DRUG LAW OFFENCES

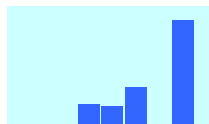
## Arrests for drug law offences

Trafficking	29
Consumption	
Total arrests	789

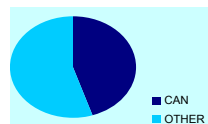
## Convictions for drug law offences

Total convictions	639
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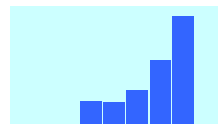
Arrests



Arrests by drug



Convictions

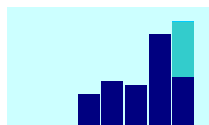


## DRUGS MARKET

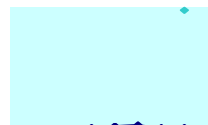
## Drug seizures

Cannabis	338
Heroin	364
Cocaine	0
Amphetamines	3
Ecstasy	0

Number of seizures



Drug prices



**Population:** 495.000 (1997)

### **Geography**

Capital of Norway. National centre of commerce, transport, culture and tourism. Unemployment rate: 4% (1997). In the 1990s rather good economic development and employment situation.

### **History and Patterns of drugs use**

Cannabis is the main illicit drug used, followed by amphetamines, ecstasy, cocaine and heroin. In the 1990s experimental use of cannabis and to a lesser extent other drugs such as ecstasy and LSD seems to increase among young adults. Problem drug use is mainly related to heroin, amphetamines and benzodiazepines. Injecting is the main route of heroin administration, but smoking of heroin is becoming more common. Heroin use stabilised in the second half of the 1990s. This population as a whole is ageing, and there is probably no increase in the incidence of young people in the group of injecting users.

### **Drug interventions and policy**

Since the 1970s several specialised facilities have been developed: inpatient centres, including a therapeutic community, outpatient centres, units in hospitals, ospitals and low-threshold services. A needle distribution programme started in 1988. Syringes are handed out by a mobile Aids Info Bus. In the 1990s the availability of drug free treatment facilities has grown. In 1993 a new law introduced compulsory treatment for drug users aged 18 and over. A pilot methadone project was initiated in Oslo in 1994 as a high-threshold maintenance programme conducted in close cooperation with inpatient and outpatient drug free treatment facilities. In 1997 the Norwegian Parliament decided to expand methadone maintenance by making it nationwide available for drug users who meet to a set of criteria.

Local drug policy is carried out along the same lines as the national drug policy. At city level drug agencies and the police frequently cooperate on drug-related issues.

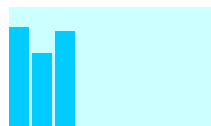
**PREVALENCE**

no (recent) data

**TREATMENT****Treatment demand**

- First treatment ■
- All treatment ■
- Mean age ■
- % < 25 ■
- % females ■

First and all treatment

**Opiate substitution**

- First substitution ■ 50 1997
- All substitution ■

first treatment	Mean age	37.0	1997
first treatment	% < 25	0.0%	1997
first treatment	% females	44.0%	1997

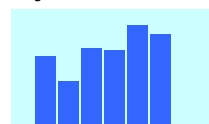
**Hospital episodes**

- Psychiatric hospitals ■
- General hospitals ■
- Non-fatal emergencies ■ 1255 1997

**HEALTH****Mortality**

- Drug related deaths ■ 95 1997

Drug related deaths

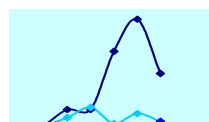
**Infectious diseases**

incidence in IDU

% IDU infected

- Hepatitis B ■ 28 1997
- Hepatitis C ■
- HIV ■ 4 1997
- Aids ■ 4 1997

Incidence in IDU

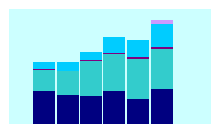
**DRUG LAW OFFENCES****Convictions for drug law offences**

- Total convictions ■ 2084 1997

**DRUGS MARKET****Drug seizures**

- Cannabis ■ 1547 1997
- Heroin ■ 1466 1997
- Cocaine ■ 94 1997
- Amphetamines ■ 833 1997
- Ecstasy ■ 138 1997

Number of seizures



**Population:** 2.131.000 (1995)

### **Geography**

Capital of France. International centre of commerce, industry (car industry), culture and tourism. Multi-ethnic cosmopolitan city. Economic activities are shifting from industries to services with job losses in the early 1990s, but improving situation later on. Unemployment rate: 10.9% (1996).

### **History and Patterns of drugs use**

Since the 1960s cannabis, LSD, amphetamines, cocaine and heroin are used. In 1989 use of 'crack' cocaine was observed for the first time. From 1993 onwards the use of ecstasy and other synthetic drugs (GBH, ketamine e.a.) increased along with the new youth (party) cultures. Survey data show a marked increase of illicit drug consumption in the 1990s. This applies also for the use of 'crack' cocaine. The main route of administration of heroin is injecting, but sniffing and smoking of heroin is gradually increasing. The illegal (and intravenously) use of Subutex (buprenorphine), a substitution drug for the medical treatment of heroin users introduced in 1995, seems to increase. For many years Rohypnol was a common used medical drug among heroin users. The use of heroin probably is decreasing.

### **Drug interventions and policy**

Drug treatment is provided by hospitals and specialised treatment centres. Drug prevention projects at schools were initiated in 1990. In 1992 a pilot needle exchange programme aimed at reducing the risk of HIV transmission was introduced in one arrondissement of the city. In 1993 the programme was expanded to other arrondissements. In 1995 a new government was launched to improve health care for drug users. The number of specialised units in clinics and hospitals was expanded, the distribution of substitution drugs was introduced and two low-threshold community centres –a drop-in centre for drug users and a shelter for homeless users– were set up. Substitution drugs for the medical treatment of heroin users are Subutex and methadone. Substitutions are prescribed by local GPs. Methadone provision demands urine testing, prescription of Subutex does not.

Local drug policy is carried out in line with national drug policy. At city level there is coordination between the police, general health care, justice authorities and the educational system. The decrease of injecting among heroin users has to some extent led to fewer nuisances perceived by the public and possibly a less negative attitude towards drug users.



## PREVALENCE

## Cannabis use

Ever (LTP)  
Recent (LYP)  
Current (LMP)

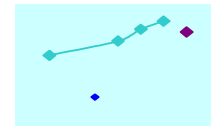
general population

school population

25.7% 1997

23.0%

Cannabis prevalence



## Problem drug use

Prevalence estimate 40000

## TREATMENT

## Treatment demand

First treatment  
All treatment

2529  
2640 1997

first treatment Mean age

33.0 1997

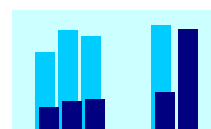
first treatment % &lt; 25

11.1% 1997

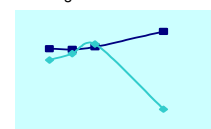
first treatment % females

27.0% 1997

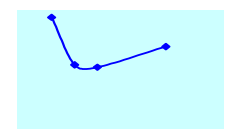
First and all treatment



Mean age and % &lt; 25



% females



## Opiate substitution

First substitution  
All substitution

2671

Mean age

% &lt; 25

% females

## HEALTH

## Injecting drug use

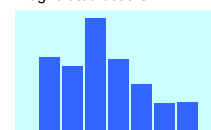
Estimated IDU prevalence  
reference: all treatment

18.0%

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths 38

## Infectious diseases

incidence in IDU

Hepatitis B

Hepatitis C

HIV

Aids

77 1997

% IDU infected

Incidence in IDU



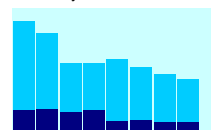
## DRUG LAW OFFENCES

## Arrests for drug law offences

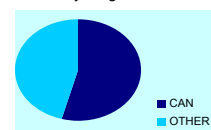
Trafficking  
Consumption  
Total arrests

621  
3128  
3749

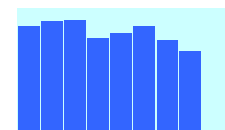
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

Total convictions 1630

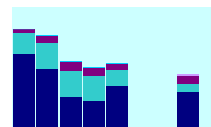
## DRUGS MARKET

## Drug seizures

Cannabis  
Heroin  
Cocaine  
Amphetamines  
Ecstasy

1810  
384  
420  
11  
51

Number of seizures



**Population:** 344.000 (1996)

### **Geography**

Perm is an industrial centre in the Western Ural region. It's is a big railway junction on the way from Asia to Europe. Population is slowly increasing due to the influx of displaced persons from CIS countries and refugees from Asia.

### **History and Patterns of drugs use**

Most illicit drugs have been observed in the city. Intravenous taking of drugs increased. Drug use tends to start increasingly at younger ages. A 1998 survey of 870 students in one of industrial areas of the town indicates, that 9.8% of them used drugs once a week or more often. In professional schools 22% of students have used drugs incidentally, 8% of the latter have abused drugs once a week or more often. Drug supply is mainly from Middle Asia and Afghanistan.

### **Drug interventions and policy**

Steady growth of registered persons with the diagnosis «addiction» is observed. The same applies to drug related first aid and medical aid in hospitals.

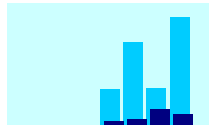
**PREVALENCE**

no (recent) data

**TREATMENT****Treatment demand**

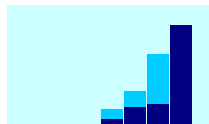
First treatment	524
All treatment	5327
Mean age	
% < 25	
first treatment % females	11.0%
	1996

First and all treatment

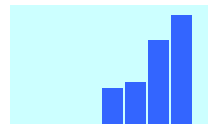
**Hospital episodes**

Psychiatric hospitals	1168
General hospitals	575
Non-fatal emergencies	1650
	1997

Hospital admissions

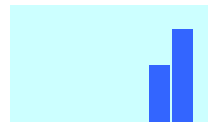


Non fatal emergencies

**HEALTH****Mortality**

Drug related deaths	24
---------------------	----

Drug related deaths

**infectious diseases**

Hepatitis B	450
Hepatitis C	
HIV	
Aids	21
	1997

incidence in IDU

% IDU infected

Incidence in IDU

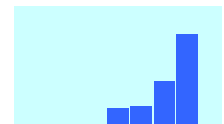
**DRUG LAW OFFENCES****Arrests for drug law offences**

Trafficking	1285
Consumption	1756
Total arrests	3041

Arrests by offence



Convictions

**Convictions for drug law offences**

Total convictions	1918
-------------------	------

**DRUGS MARKET**

no (recent) data

**Population:** 1.207.000 (1998)

### **Geography**

Capital city of the Czech Republic. National centre of transport, commerce, industry, culture and tourism. Positive economic development in the 1990s. Rapid expansion of third sector services. Increasing capital investment, also from abroad. Unemployment rate: 0.9% (1997).

### **History and Patterns of drugs use**

Drugs appeared first in the period of student unrest at the end of the 1960s. During the 1970s and the 1980s drug use remained a marginal and hidden phenomenon. Drugs used were mostly pharmaceuticals. The typical drug of 1980s were homemade pervitin (a methamphetamine) and Braun (an opiate containing codeine). With the socio-political changes in 1989 the country started a difficult process transformation and an dramatic increase in drug consumption. Pharmaceuticals containing psychoactive substances (particularly opiates or stimulants) and volatile substances were most commonly used drugs. In recent years the use of these pharmaceuticals has been rather stable, but the use of 'new' drugs has increased considerably, especially the recreational use of cannabis and hallucinogens among (outgoing) young people. Heroin entered the market in the 1990s and is mostly used intravenously.

### **Drug interventions and policy**

In the past drug treatment was provided by psychiatric outpatient services specialised on the treatment of alcohol and drug use-related problems, and specialised departments of psychiatric and general hospitals. Since the beginning of the 1990s the health care system has been reformed, which included the privatisation of health care facilities and decentralisation of services. In the field of drug treatment and care the number of non-governmental organisations has grown. Among these there are new low-threshold centres that are more flexible of adopting less traditional approaches in treatment, rehabilitation, and counselling. Recent developments are syringe and needle exchange programmes, substitution therapy (though on a rather limited scale) and long-term treatment in therapeutic communities.

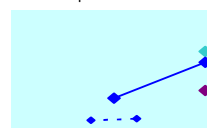
With respect to intervention control priority is given to police intervention and prosecution. In 1994 a new Penal Code has been introduced. Individual use and possession of drugs for personal use is not a criminal offence. Offenders of a drug laws can voluntary apply for treatment. The Anti-drug Commission of the Municipality of Prague, formed by representatives from local authorities, the police and drug, health and social agencies, formulates priorities for drug policy in the city. One of the major policy goals is to create a balance between repressive and preventive measures. In the 1990s drug use, particularly regarding young people, has become a subject of public concern and debate.

## PREVALENCE

## Cannabis use

	general population		school population	
Ever (LTP)			39.4%	1999
Recent (LYP)	6.3%	1996	34.1%	1999
Current (LMP)			20.2%	1999

## Cannabis prevalence

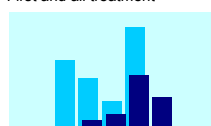


## TREATMENT

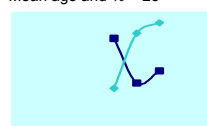
## Treatment demand

First treatment	533	1997
All treatment	1578	1996
first treatment Mean age	21.1	1997
first treatment % < 25	83.7%	1997
first treatment % females	42.6%	1997

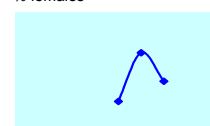
## First and all treatment



## Mean age and % &lt; 25



## % females



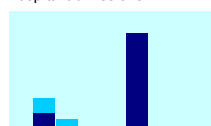
## Opiate substitution

First substitution		
All substitution	25	1997
Mean age		
% < 25		
% females		

## Hospital episodes

Psychiatric hospitals	983	1996
General hospitals		
Non-fatal emergencies	38	1997

## Hospital admissions



## HEALTH

## Injecting drug use

Estimated IDU prevalence	70.0%	1997
reference: all treatment		

## infectious diseases

	incidence in IDU	% IDU infected
Hepatitis B	11	1997
Hepatitis C	43	1997
HIV	3	1997
Aids	0	1997

## Incidence in IDU

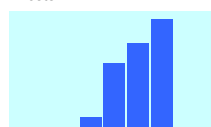


## DRUG LAW OFFENCES

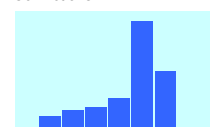
## Arrests for drug law offences

Trafficking		
Consumption		
Total arrests	279	1997

## Arrests



## Convictions



## Convictions for drug law offences

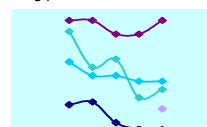
Total convictions	81	1997
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## DRUGS MARKET

## Drug seizures

Cannabis	32	1997
Heroin	14	1997
Cocaine	10	1997
Amphetamines	13	1997
Ecstasy		

## Drug prices



**Population:** 1.142.000 (1996)

### **Geography**

Capital city of Bulgaria. National centre of economic activity. Socio-political changes at the beginning of the 1990s have put the economy in a crisis. Relatively high level of unemployment.

### **History and Patterns of drugs use**

In the mid-1960s small groups influenced by youth subcultures in the Western world, started to use drugs, mainly opiates like morphine, codeine. Injecting was the common route of administration. A second wave of drug use appeared between the mid-1970s and the mid-1980s. This involved opiates, benzodiazepines, hallucinogenic medicines (antiparkinson medicines) and solvents. The third wave started in the late 1980s in a period of liberalisation and large transitions in society. From 1991-92 onwards the use of illicit drugs has been steadily increased. A new generation of heroin users appeared; most of them injected their drugs. There is no evidence for home production of heroin in Bulgaria. Volatile substance abuse decreased. Cocaine (sniffing) is possibly used by selected groups. Next to cannabis, new drugs like ecstasy gained popularity among young people. School survey data indicate that cannabis is the most common used drug among students aged 14-18 years. In 1995 the number of drug users in the city was estimated at 10000-15000, from which approximately 4000-5000 probably are a regular user. Although injecting still is the main route of heroin administration, recently chasing the dragon has been observed among young heroin users and long-term users who switch because of physical problems with intravenous use.

### **Drug interventions and policy**

Before 1993 all activities concerning drug problems were developed by different institutions more or less separately. In 1992-93 more integrated demand and supply reduction policies started. An important stage in this process was the establishment of the National Inter-ministerial Council to Combat Illicit Trafficking and Drug Misuse. Its main goal is to coordinate and consolidate the activities of all institutions engaged with drug problems. Today, the main treatment facility in Sofia is incorporated in the National Centre for Addictions (NCA). NCA has been the basis for the development of a number of inpatient and outpatient programmes, including a methadone maintenance programme and prevention projects schools.

Under the Public Health Law the Ministry of Health controls the production, processing, storage, import, export and accountancy of psychotropic substances and their precursors. There is a fine for distributing opiate substances. At present it is considered to develop laws on compulsory treatment for convicted drug users.

## PREVALENCE

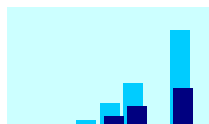
no (recent) data

## TREATMENT

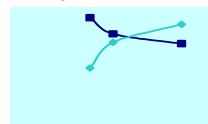
## Treatment demand

First treatment	395
All treatment	974
first treatment Mean age	21.0
first treatment % < 25	85.8%
first treatment % females	19.2%

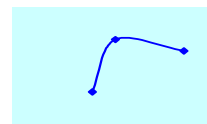
First and all treatment



Mean age and % &lt; 25



% females



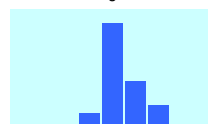
## Opiate substitution

First substitution	240
All substitution	240
all treatment Mean age	27.2
all treatment % < 25	52.1%
all treatment % females	23.3%

## Hospital episodes

Psychiatric hospitals	
General hospitals	
Non-fatal emergencies	338 1997

Non fatal emergencies

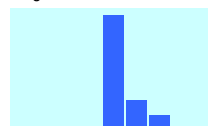


## HEALTH

## Injecting drug use

Estimated IDU prevalence	75.0%	1997
reference unknown		

Drug related deaths



## Mortality

Drug related deaths	20	1997
---------------------	----	------

## infectious diseases

incidence in IDU

% IDU infected

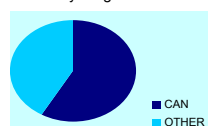
Hepatitis B	17.5%	1997
Hepatitis C	77.5%	1997
HIV	3.5%	1997
Aids		

## DRUG LAW OFFENCES

## Arrests for drug law offences

Trafficking	244
Consumption	
Total arrests	244

Arrests by drug



## Convictions for drug law offences

Total convictions	70	1997
-------------------	----	------

## DRUGS MARKET

## Drug seizures

Cannabis	7
Heroin	20
Cocaine	8
Amphetamines	1
Ecstasy	

**Population:** 718.000 (1996)

No context information available.



## PREVALENCE

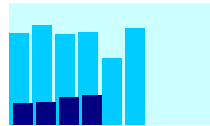
no (recent) data

## TREATMENT

## Treatment demand

First treatment			
All treatment	2375	1996	
Mean age			
first treatment % < 25	10.4%	1996	
first treatment % females	28.0%	1996	

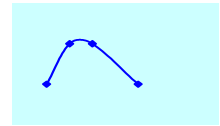
First and all treatment



Mean age and % &lt; 25



% females

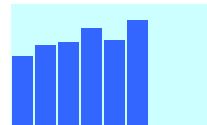


## HEALTH

## Mortality

Drug related deaths	61	1996
---------------------	----	------

Drug related deaths

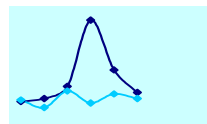


## infectious diseases

	incidence in IDU	
Hepatitis B	23	1996
Hepatitis C		
HIV		
Aids	19	1996

% IDU infected

Incidence in IDU

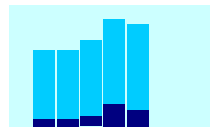


## DRUG LAW OFFENCES

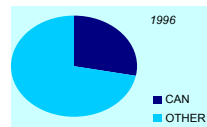
## Arrests for drug law offences

Trafficking	221	1996
Consumption	1127	1996
Total arrests	1348	1996

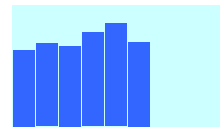
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

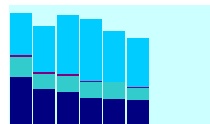
Total convictions	1731	1996
-------------------	------	------

## DRUGS MARKET

## Drug seizures

Cannabis	754	1996
Heroin	368	1996
Cocaine	21	1996
Amphetamines	1411	1996
Ecstasy		

Number of seizures



**Population:** 4.716.000 (1998)

### **Geography**

St.Petersburg is one of the biggest metropolitan areas of Europe, where 4.5% of urban population of Russia lives. Socio-demographic processes in St-Petersburg are similar to those, which are observed for Russia as a whole. Main demographic trends: population decrease, in particular in the younger age groups. St.Petersburg is an important industrial, commercial and transport centre. General economic situation is a bit better than compared to Moscow or other Russian cities. The official unemployment rate in 1997 was 9%. Due to its location the city is more open to influences from other countries, which affects the drug situation (diffusion of lifestyles, import and transit of drugs).

### **History and Patterns of drugs use**

A sharp increase in the use of illicit drugs has been noted after the 1995 anti-alcohol campaign. Homemade opiates and cannabis are the prevailing drugs. In the late 1990s an aggressive spreading of heroin on the drug market is observed, replacing homemade opiates and combined with a sharp increase of drug injecting. The trend coincides with a decrease of both quality and prices of street heroin. Prevalence of drug use is thought to be higher than in other areas of Russia. The increase of drug addiction is reflecting the rapid social, economic and political changes in the last 15 years: split of society into poor and rich, increased crime, ideological vacuum in formation.

### **Drug interventions and policy**

Treatment demand increases in particular related to heroin use. The city has 35 centres for inpatient and outpatient treatment. In recent years a large number of specialised social services emerged: centres for assistance to families, hotlines for teenagers, self-help groups. Beside the state of city-financed centres also commercial ones have appeared and drug treatment is also provided by private practitioners. Their interventions are however not covered in official statistics. Local drug policies are in line with state policies and are coordinated by the Coordination Council on Counteracting Narcotics and Narcobusiness.






## PREVALENCE

## Problem drug use

Prevalence estimate 1974

## TREATMENT

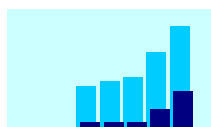
## Treatment demand

	First treatment		2623
	All treatment		6881
first treatment	Mean age		23.0
first treatment	% < 25		79.3%
first treatment	% females		23.6%

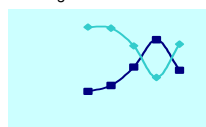
## Hospital episodes

Psychiatric hospitals	3810
General hospitals	261
Non-fatal emergencies	3342

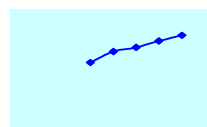
First and all treatment



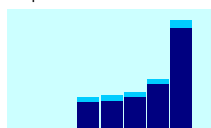
Mean age and % &lt; 25



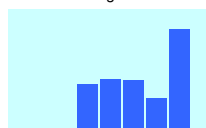
% females



Hospital admissions



Non fatal emergencies



## HEALTH

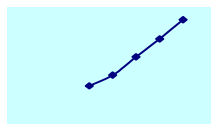
## Injecting drug use

Estimated IDU prevalence 93.0%  
reference: all treatment

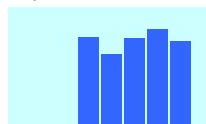
## Mortality

Drug related deaths 86

Prevalence of IDU



Drug related deaths



## infectious diseases

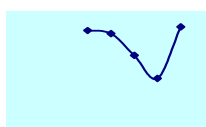
incidence in IDU

Hepatitis B	520
Hepatitis C	
HIV	
Aids	7 1996

% IDU infected

1.3% 1996

Incidence in IDU

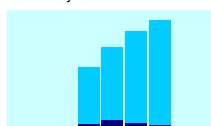


## DRUG LAW OFFENCES

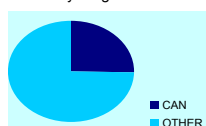
## Arrests for drug law offences

Trafficking	261	1997
Consumption	4303	1997
Total arrests	8744	

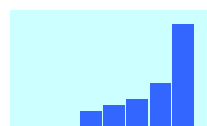
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

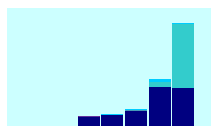
Total convictions 5285

## DRUGS MARKET

## Drug seizures

Cannabis	2451
Heroin	3654
Cocaine	15
Amphetamines	48
Ecstasy	

Number of seizures



Drug prices



**Population:** 305.000 (1997)

### **Geography**

Seaport on the Black Sea. Transport, industrial and tourist centre. Negative economic development in the early 1990s, recovering since 1997.

### **History and Patterns of drugs use**

In the late 1960s drug use was concentrated in a small subgroup of users of opiates, tranquillisers and barbiturates. In the 1980s new patterns emerged of abuse of medicines in combination with alcohol and of solvents sniffing among children of 10-12 years. The situation really changed with the democratic development in the late 1980s and early 1990s when heroin appeared on the local market, followed by an increase in treatment demands, non-fatal emergencies and Hepatitis B cases. A group of a few hundred heroin users in the minority group of Gypsies constitute a specific local problem.

Main drugs today are cannabis, heroin, medicines in combination with alcohol, cocaine and ecstasy. School survey data show that in 1997 cannabis is the most popular drug among pupils aged 15-18 years, followed by tranquillisers and barbiturates. Among heroin users injecting is the main route of heroin administration, though not so among heroin users from ethnic minorities (Arabs, Iranians, Gypsies). Cocaine use seems to be restricted among the 'nouveau riche'.

### **Drug interventions and policy**

Inpatient and outpatient units for medical treatment and psychotherapy of drug users are available since 1973. Intervention facilities have been extended since the early 1990s, including today school prevention projects and syringe exchange programme.

Varna has a Permanent Commission on Drug Problems in which local authorities, specialised drug agencies, general health and social agencies, the police, the educational system and justice authorities participate. The focus of local policy is on prevention measures.

## PREVALENCE

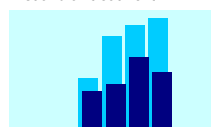
no (recent) data

## TREATMENT

## Treatment demand

First treatment	39	1997
All treatment	75	1997
first treatment Mean age	21.7	1997
first treatment % < 25	79.0%	1997
first treatment % females	15.0%	1997

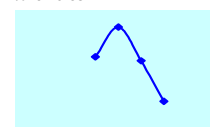
First and all treatment



Mean age and % &lt; 25



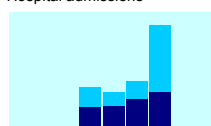
% females



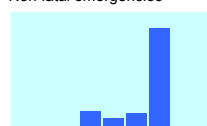
## Hospital episodes

Psychiatric hospitals	48	1997
General hospitals	77	1997
Non-fatal emergencies	104	1997

Hospital admissions



Non fatal emergencies



## HEALTH

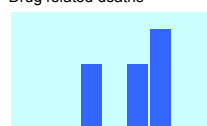
## Injecting drug use

Estimated IDU prevalence	68.0%	1997
reference: all treatment		

Prevalence of IDU



Drug related deaths



## Mortality

Drug related deaths	3	1997
---------------------	---	------

## infectious diseases

incidence in IDU

Hepatitis B	5	1997
Hepatitis C		
HIV		
Aids	0	1997

% IDU infected

Incidence in IDU

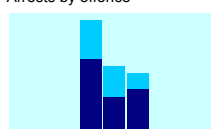


## DRUG LAW OFFENCES

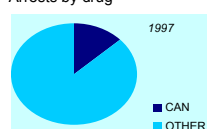
## Arrests for drug law offences

Trafficking	6	1996
Consumption	2	1996
Total arrests	23	1997

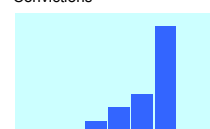
Arrests by offence



Arrests by drug



Convictions



## Convictions for drug law offences

Total convictions	8	1997
-------------------	---	------

## DRUGS MARKET

no (recent) data

**Population:** 1.629.000 (1996)

### **Geography**

Capital city of Poland. National centre of trade, industry, culture and tourism and international transport junction on the East-West route. Unemployment rate: 2.8% (1997). Warsaw's current rate of economic growth is higher than the average for Poland as a whole.

### **History and Patterns of drugs use**

Drug use was first observed in the late 1960s. The scene was at first dominated by home made opiates, volatile substances, sedatives and sleeping pills. This has changed in the 1990s when cannabis, amphetamines, hallucinogens and synthetic drugs became more common drugs, in particular among young people and often related to specific lifestyle subcultures. School survey data indicate that cannabis is the most common illicit drug used, followed by amphetamines and LSD. However, sedatives, tranquillisers and solvents are still more common than any illicit drugs other than cannabis. Problem drug use mainly regards heroin and other opiates. The main route of administration of opiates is injecting. Treatment demand data indicate that a new pattern of problem use has emerged related to amphetamines and cannabis.

### **Drug interventions and policy**

Treatment and rehabilitation is provided by several specialised centres. Some experimental methadone programmes have been implemented in Warsaw, but methadone therapy is not yet regarded a routine treatment method. In order to ensure access of drug users to social assistance and support, a foundation has been established to improve cooperation between the city's social assistance centres and treatment services.

In 1997 the police structure responsible for drug-related issues has been changed. The main focus is combating illegal drug production (poppy and hemp cultivation) and trafficking of drugs, and the prevention of production and trafficking of new substances like amphetamines and cannabis. The police are usually more tolerant towards individual users of kompot, who produce it for their own consumption or sell small amounts.

The revised laws on drugs of 1997 include a legal basis for substitution treatment, control over precursors and extension of probation mechanism. The law of 1997 was preceded by several years of public debate, parallel to the resettling of the Polish drug scene in the 1990s. News media paid much attention at the problems related to transitions in the illegal drug market and the increase of use among young people.

## PREVALENCE

no (recent) data

## TREATMENT

## Treatment demand

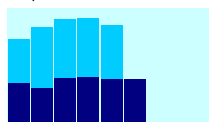
First treatment	270	1996
All treatment	1023	1996

first treatment	Mean age	24.0	1996
first treatment	% < 25	71.5%	1996
first treatment	% females	18.1%	1996

## Hospital episodes

Psychiatric hospitals	292	1996
General hospitals		
Non-fatal emergencies		

Hospital admissions

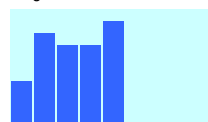


## HEALTH

## Mortality

Drug related deaths

Drug related deaths



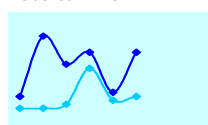
## infectious diseases

incidence in IDU

% IDU infected

Hepatitis B		
Hepatitis C		
HIV	20	1996
Aids	9	1996

Incidence in IDU

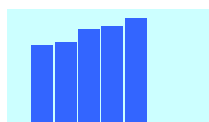


## DRUG LAW OFFENCES

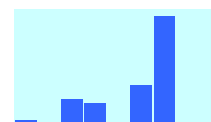
## Arrests for drug law offences

Trafficking		
Consumption		
Total arrests	4600	1996

Arrests



Convictions



## Convictions for drug law offences

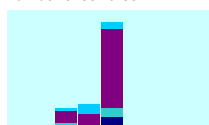
Total convictions	33	1997
-------------------	----	------

## DRUGS MARKET

## Drug seizures

Cannabis	
Heroin	
Cocaine	
Amphetamines	
Ecstasy	

Number of seizures



**Population:** 628.000 (1996)

### **Geography**

Situated north east of Moscow in the Russian heartland. About 37% of the population is in the age group 15-39 years. Compact city with no suburban area. Main industries are oil refining and engine building.

### **History and Patterns of drugs use**

Drug problems started in the early 1990s with homemade opiates and cannabis as the most popular drugs. Situation keeps worsening, but official figures are still quite low. Registered drug addicts increased from 29 in 1994 to 77 in 1996, among them no children and teenagers. Heroin and methadone abuse has been observed in recent years. Among youngsters ecstasy became widely spread. Based on treatment data the increase of drug abuse is coincides with the migration of refugees from southern regions of the former Soviet Union. Intravenous drug use is increasing.

### **Drug interventions and policy**

Treatment demand increases, majority of treatment demands relate to opiate users. Treatment is provided by specialised psychiatric centres. Health indicators show increasing problems. Police interventions also increase.

Drug policies are developed and implemented by a regional committee to combat drug use and illegal drug trafficking, based on a formal regional programme.



## PREVALENCE

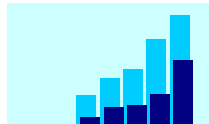
no (recent) data

## TREATMENT

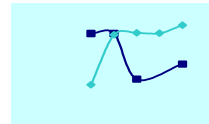
## Treatment demand

First treatment	160
All treatment	271
first treatment Mean age	24.0
first treatment % < 25	81.8%
first treatment % females	17.5%

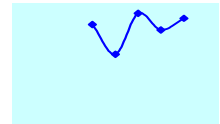
First and all treatment



Mean age and % &lt; 25



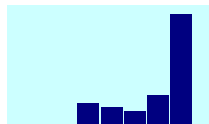
% females



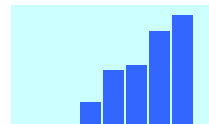
## Hospital episodes

Psychiatric hospitals	231
General hospitals	
Non-fatal emergencies	229

Hospital admissions



Non fatal emergencies

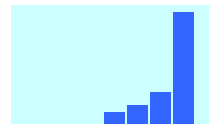


## HEALTH

## Mortality

Drug related deaths	17
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Drug related deaths



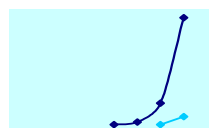
## infectious diseases

incidence in IDU

Hepatitis B	42
Hepatitis C	
HIV	
Aids	5

% IDU infected

Incidence in IDU

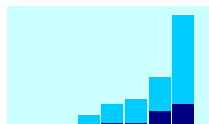


## DRUG LAW OFFENCES

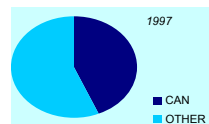
## Arrests for drug law offences

Trafficking	158
Consumption	583
Total arrests	741

Arrests by offence



Arrests by drug



## Convictions for drug law offences

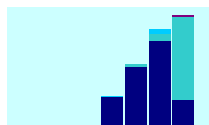
Total convictions	292
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## DRUGS MARKET

## Drug seizures

Cannabis	48
Heroin	135
Cocaine	3
Amphetamines	7
Ecstasy	

Number of seizures



Drug prices





**4**

# **EUROPEAN TRENDS**



# INDICATOR TRENDS

## ACCOUNT OF DATA PRESENTATION

In this section we present trends in individual indicators across Europe. As before, indicators are grouped along the categories of prevalence, treatment, health, drug law offences and drugs market. Trend information is presented as far as predefined selection criteria are met in two different formats.

- *Tables of recent indicator values and/or trends per city*

The tables have been constructed if we have recent figures of at least 10 cities. As in the case of the city profiles, 'recent' means a figure of 1996 or later. In general figures refer to 1998, if not the appropriate year is listed in italics next to a figure. Whenever applicable figures are presented as RATES per 100.000 of the city's population.

Trends refer to the period 1991-1998. Trend orientation is presented by the following symbols:

	<b>UP</b>
	<b>DOWN</b>
	<b>STABLE</b>

Trends have been assessed as by calculating the slope of a linear regression line to identify trend orientation and Pearson's product moment correlation coefficient to identify trend significance. Although a linear model not always provides a best fit for actual trend developments, it is assumed to be appropriate for the purpose of rapid trend assessment. Trends are labelled UP or DOWN when Pearson's  $R^2 > 0.5$ , otherwise a trend is labelled as STABLE. No trends are indicated if we have less than 3 data for the reporting period.

- *Thematic maps showing relative magnitude of indicators and trends per city*

Maps present indicator data as circles or pie charts on each city. The size of circles is relative to the indicator figure or, whenever applicable, the rate per 100.000. For practical reasons figures and rates refer to AVERAGE figures and rates for the years 1996-1998. Slices of pie charts are relative to the percentage of a subcategory of an indicator.

Colours of circles or slices indicate trend orientation, whereby the labelling as UP (red), DOWN (blue) or STABLE (yellow) follows the rules described above. If no trend can be assessed because we have less than 3 figures, circles and slices are given a neutral grey colour.

Maps are only included for a selection of indicators.

## PREVALENCE

Last month prevalence in % among school population				trend
Amsterdam	23.0%	1997	4	▲
Paris	23.0%		1	
Madrid	20.7%	1997	1	
Prague	20.2%		1	
Gdansk	8.7%	1997	3	●
Bratislava	8.5%		2	
Athens	8.2%		2	
Lisbon	6.3%	1998	3	▲
Moscow	3.5%	1999	1	
Malta	2.7%		2	

## TREATMENT

All treatment demand per 100.000 of population				trend	% first treated
Perm	1548		4	●	10%
Krasnodar	749		5	●	35%
Amsterdam	426		8	▼	7%
Novosibirsk	409		5	▲	18%
Dublin	366		8	▲	26%
Kaliningrad	360		3	●	13%
Stockholm	338	1996	6	●	
Copenhagen	336	1997	4	▲	15%
Hamburg	295	1996	4	▲	56%
Liege	270	1996	2		67%
Moscow	236		5	▲	52%
Budapest	234		5	▲	65%
Kemerovo	234		4	▲	72%
Bratislava	229		4	▲	35%
Barcelona	220	1997	7	●	39%
Malta	211	1999	6	▲	17%
Madrid	193		2		
Brussels	190	1997	1		
Gdansk	175		5	▲	28%
Orenburg	168		5	▲	69%
Geneva	167	1997	7	●	24%
St.Petersburg	145		5	▲	38%
Jekaterinburg	131		1		46%
Prague	130	1996	4	●	34%
Paris	124	1997	4	▲	96%
Ljubljana	84	1997	7	▲	54%
Sofia	83		4	▲	41%
Warsaw	63	1996	2		26%
Debrecen	51	1997	1		77%
Yaroslavl	43		5	▲	59%
Varna	23	1997	4	▲	52%
Athens	22		5	●	44%

First treatment demand per 100.000 of population				trend	mean age	trend	% females	trend
Krasnodar	259		5	▲	22.2	●	12%	●
Liege	182	1996	1		24.5			
Kemerovo	167		4	▲	20.7		23%	●
Hamburg	165	1996	4	●			32%	●
Budapest	153		5	▲			36%	▲
Perm	152		4	▲			11%	
Moscow	123		5	▲			19%	●
Paris	119		5	▲	33.0	▲	27%	●
Orenburg	117		5	▲	22.2		6%	●
Dublin	95		8	●	21.7	●	32%	▲
Barcelona	86	1997	7	●	28.0	●	22%	▼
Bratislava	81		4	▼	21.9	▲	31%	●
Novosibirsk	73		5	●			15%	●
Charleroi	63		1		24.7		15%	
Helsinki	62	1996	6	●				
Jekaterinburg	61		1					
St.Petersburg	55		5	▲	23.0	●	24%	▲
Copenhagen	51	1997	4	●	31.7	▲	24%	●
Gdansk	48		5	▲	18.7	▼	26%	●
Ljubljana	45	1997	7	▲	23.2	●	24%	▼
Kaliningrad	45		3	●	25.7	▲	21%	▼
Prague	44	1997	5	▲	21.1	●	43%	●
Geneva	41	1997	7	●	27.7	▲	15%	●
Debrecen	39	1997	1				18%	
Malta	35	1999	6	●	24.7	●	16%	▲
Sofia	34		4	▲	21.0	▼	19%	●
Amsterdam	28		8	▼	34.2	▲	28%	●
Yaroslavl	26		5	▲	24.0	●	18%	●
Warsaw	17	1996	2		24.0		18%	
Varna	12	1997	4	▲	21.7	●	15%	▼
Albania	10	1997	3	▲			8%	▼
Athens	10		5	●	34.1	●	19%	●

Admissions to general hospitals per 100.000 of population				trend
Perm	167	1997	3	▲
Hamburg	29	1997	5	▲
Novosibirsk	27		4	▲
Varna	24	1997	4	▲
Krasnodar	22		5	●
Orenburg	10		5	●
St.Petersburg	5		5	●
Helsinki	5		7	●
Ljubljana	0	1996	6	▼

Admissions to psychiatric hospitals per 100.000 of population				trend
Perm	339		4	▲
Liege	267	1996	1	
Moscow	117		5	▲
Krasnodar	105		5	●
Kemerovo	82		4	●
Prague	81	1996	2	
St.Petersburg	80		5	▲
Hamburg	78	1997	5	▲
Helsinki	67		7	▲
Novosibirsk	50		5	●
Yaroslavl	37		5	▲
Orenburg	25		5	●
Warsaw	18	1996	6	●
Varna	15	1997	4	▲
Ljubljana	14	1996	6	●
Kaliningrad	10		2	

Drug related non-fatal emergencies per 100.000 of population				trend
Perm	479		4	▲
Oslo	260	1997	1	
Barcelona	192	1997	7	▼
Orenburg	117		5	▲
Kemerovo	101		1	
Hamburg	88	1996	4	▼
Amsterdam	84		8	●
Budapest	83		3	▲
Gdansk	79		8	▲
St.Petersburg	70		5	●
Krasnodar	53		5	▼
Liege	40	1996	1	
Yaroslavl	37		5	▲
Malta	35	1999	3	●
Jekaterinburg	35		1	
Varna	33	1997	4	▲
Ljubljana	31	1997	4	▲
Novosibirsk	30		3	▲
Sofia	29	1997	4	●
Madrid	25		2	
Kaliningrad	7		3	▼
Charleroi	4		1	
Prague	3	1997	2	

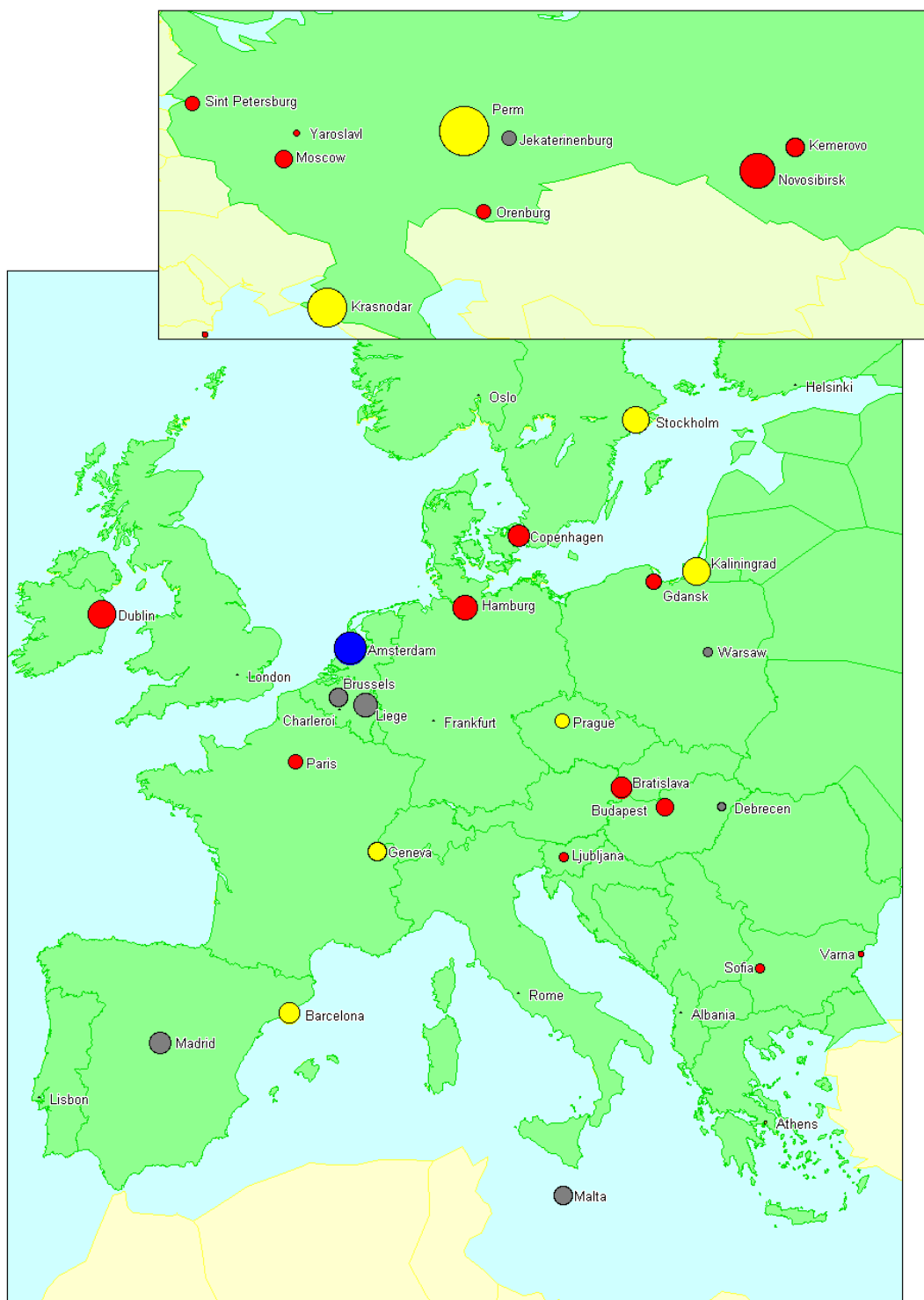


## All Treatment Demand

Size of circles is relative to **RATE of ALL TREATMENT DEMAND** per 100.000 of population

Colours of circles indicate **TREND of ALL TREATMENT DEMAND**:

● **UP** ● **DOWN** ● **STABLE** ● **no trend available**



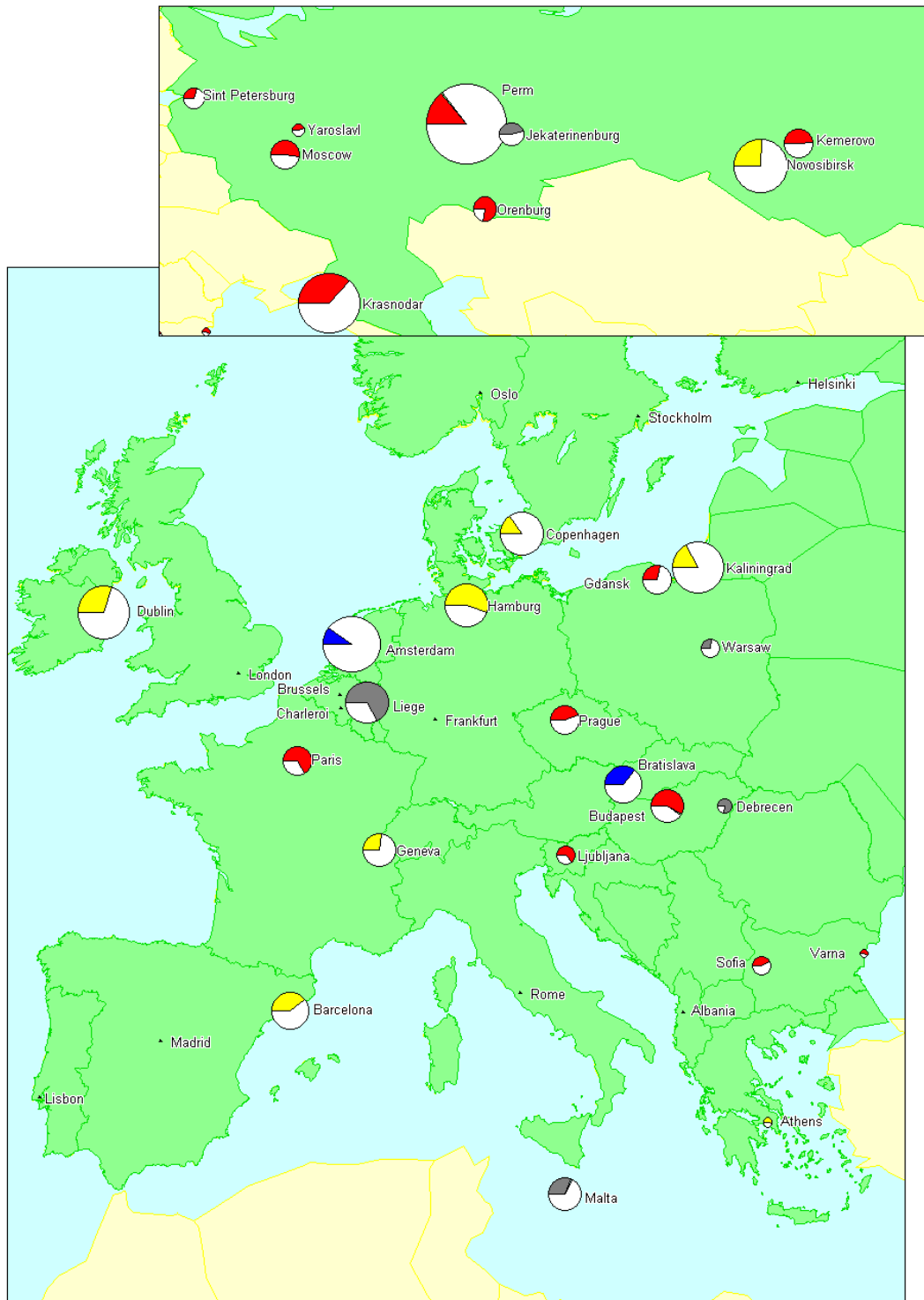
## % First treated of all treatment demand

Size of circles is relative to **RATE of ALL TREATMENT DEMAND** per 100.000 of population

Size of slices is relative to % **FIRST TREATED** of all treatment demand

Colours of slices indicate **TREND of FIRST TREATMENT DEMAND**:

● **UP**      ● **DOWN**      ● **STABLE**      ● **no trend available**

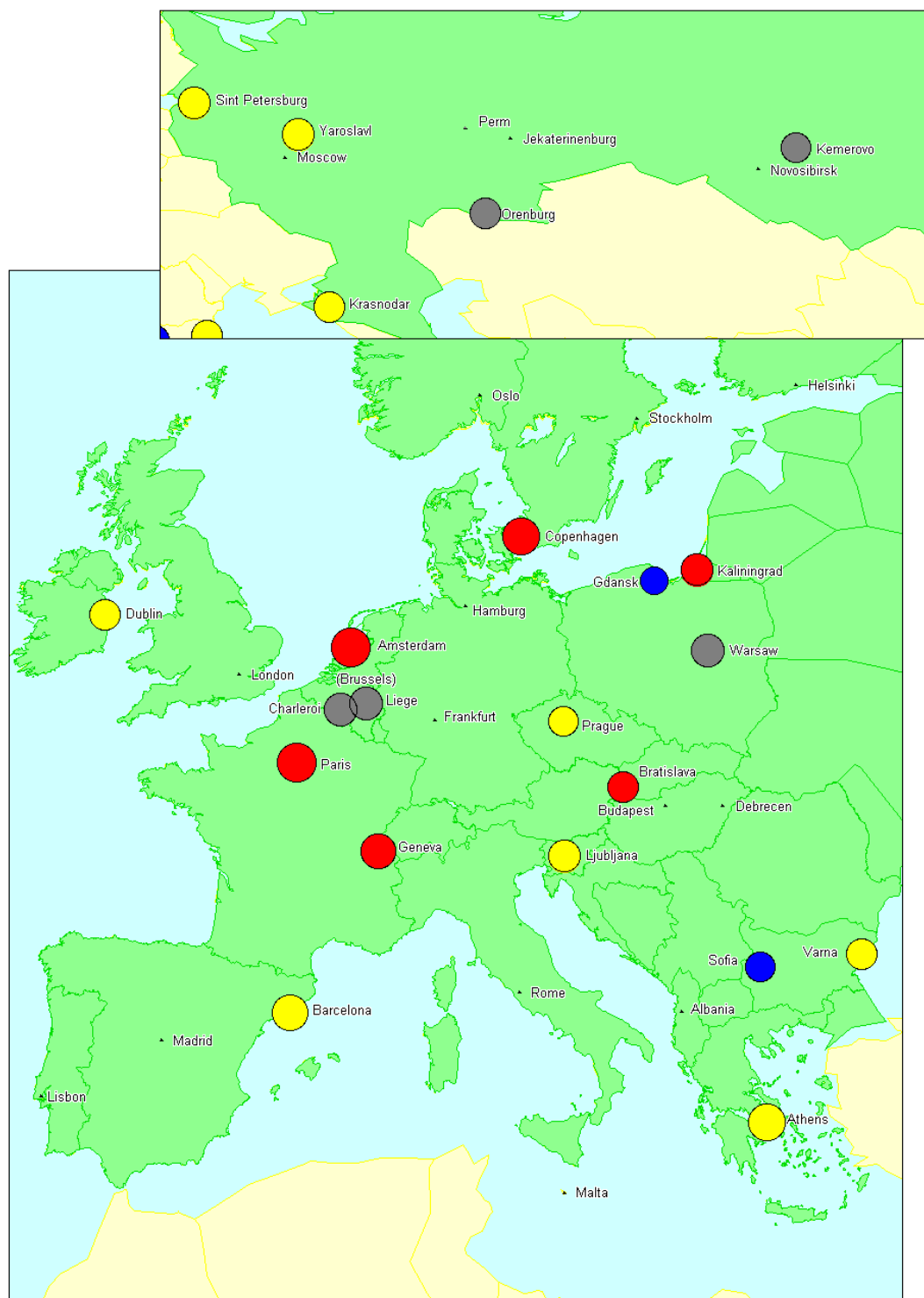


## Mean age first treatment demand

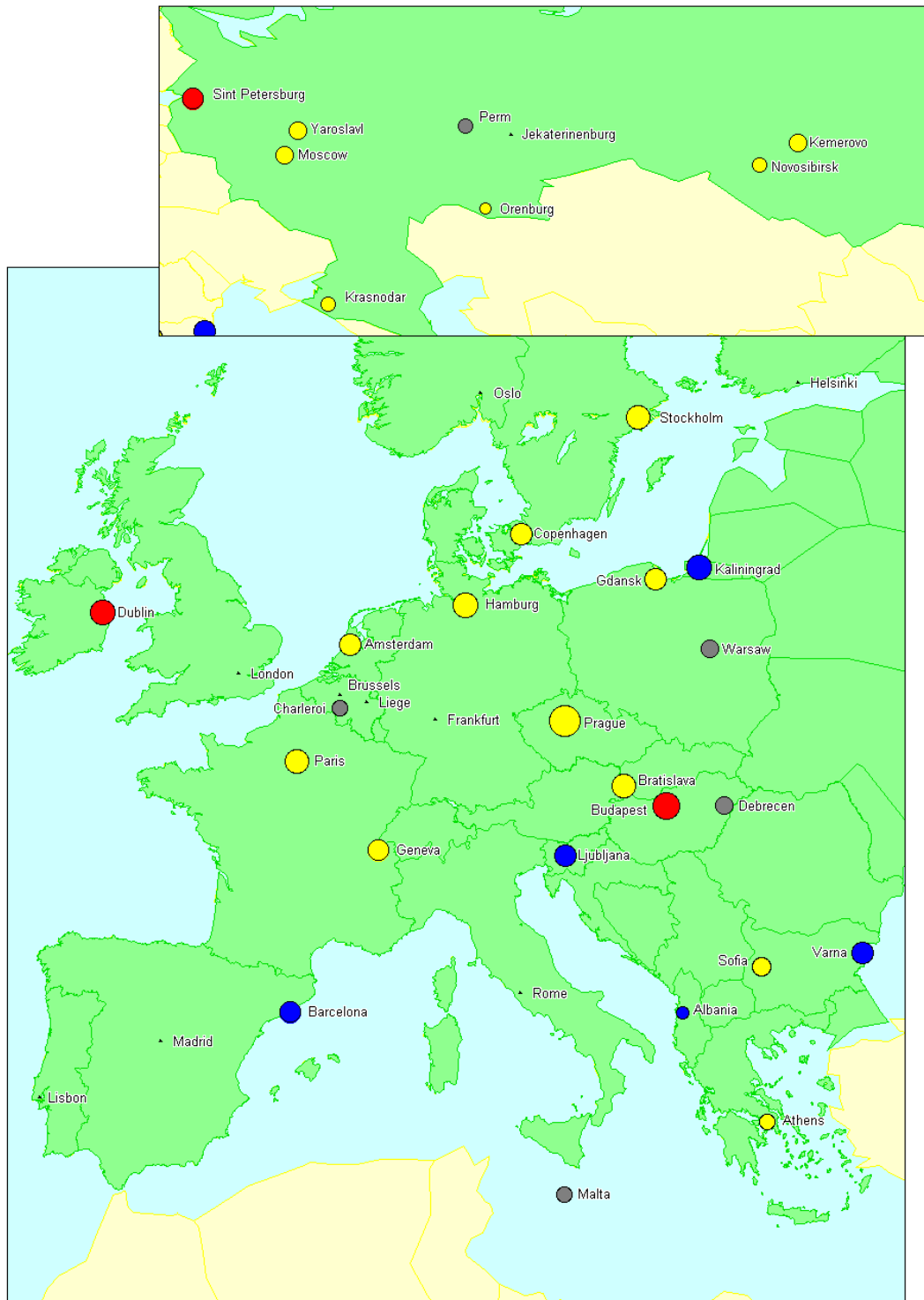
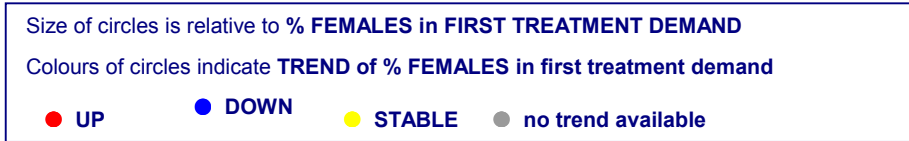
Size of circles is relative to **MEAN AGE in FIRST TREATMENT DEMAND**

Colours of circles indicate **TREND of MEAN AGE in first treatment demand**:

● **UP**      ● **DOWN**      ● **STABLE**      ● **no trend available**



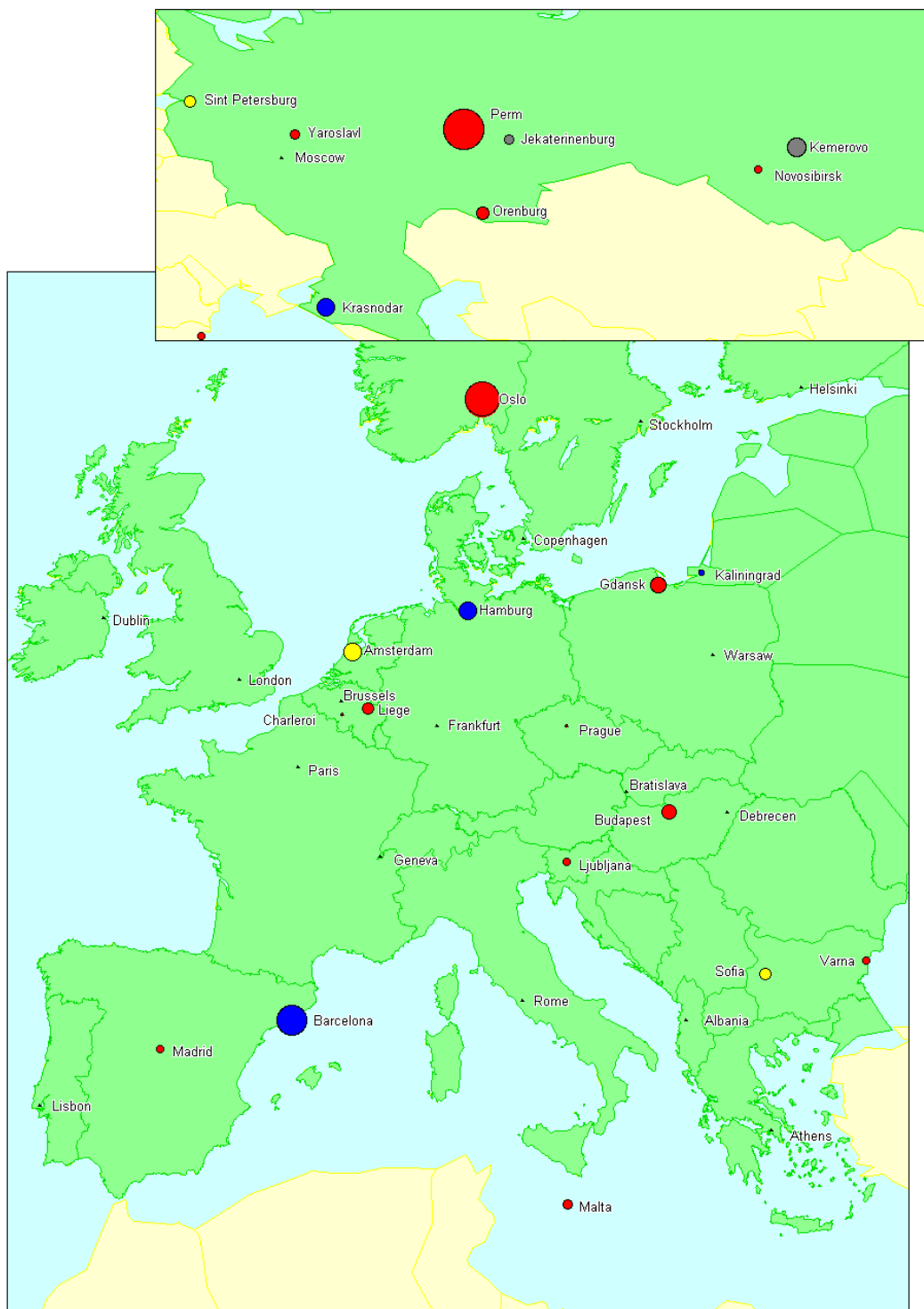
## % Females in first treatment demand



## Drug related non-fatal emergencies

Size of circles is relative to **RATE of NON-FATAL EMERGENCIES** per 100.000 of population  
Colours of circles indicate **TREND in NON-FATAL EMERGENCIES**

● **UP**      ● **DOWN**      ● **STABLE**      ● **no trend available**



## HEALTH

Drug related deaths per 100.000 of population				trend	N of cases
Oslo	19.6	1997	6	▲	95
Copenhagen	15.5	1997	7	▲	73
Kemerovo	14.9		4	▲	76
Dublin	14.8		4	▲	136
Lisbon	11.5		7	●	212
Jekaterinburg	10.7		1		141
Budapest	10.6	1997	3	▲	207
Stockholm	8.7	1996	6	▲	61
Orenburg	8.4		5	▲	45
Geneva	7.9	1996	6	●	31
Athens	7.8		8	▲	239
Barcelona	7.7	1997	7	▼	122
Hamburg	7.5	1997	5	●	127
Perm	7.0		5	▲	24
Gdansk	6.1		8	▲	46
Madrid	5.9		2		170
Novosibirsk	5.5		4	▲	77
Charleroi	5.4		1		11
Krasnodar	4.6		5	▼	35
Bratislava	4.0		1		18
Amsterdam	3.5		8	▼	25
Moscow	3.3		3	▲	285
Ljubljana	3.1	1997	7	●	10
Kaliningrad	2.8		3	▼	12
Yaroslavl	2.7		4	▲	17
Helsinki	2.6		8	●	14
Malta	2.1	1999	3	●	8
St.Petersburg	1.8		5	●	86
Paris	1.8		7	▼	38
Sofia	1.7	1997	3	▼	20
Varna	0.9	1997	4	●	3

Estimated % injectors among drug users				trend	reference population
Gdansk	96%		5	▲	unknown
St.Petersburg	93%		5	▲	all treatment demand
Hamburg	90%	1996	2		all treatment demand
Kaliningrad	87%	1997	2		all treatment demand
Krasnodar	85%		4	▲	first treatment demand
Novosibirsk	83%		3	●	all treatment demand
Orenburg	83%		5	▲	all treatment demand
Bratislava	78%		1		unknown
Sofia	75%	1997	1		unknown
Prague	70%	1997	1		all treatment demand
Varna	68%	1997	4	▼	all treatment demand
Charleroi	56%		1		unknown
Athens	52%	1997	4	▼	first treatment demand
Barcelona	41%	1997	7	▼	all treatment demand
Dublin	35%	1996	1		all treatment demand
Geneva	34%	1997	7	●	first treatment demand
Albania	34%	1997	3	●	first treatment demand
Budapest	26%	1997	3	●	all treatment demand
Madrid	22%		2		unknown
Amsterdam	21%		1		unknown
Paris	18%		3	▼	all treatment demand
Copenhagen	15%	1997	4	▼	all treatment demand
Malta	6%	1997	1		first treatment demand

Incidence of Hepatitis B among IDU per 100.000 of population				trend	N of cases
Perm	130.7	1997	3	▲	450
Kemerovo	38.6		3	●	197
Novosibirsk	23.4		4	●	327
Orenburg	18.7		5	▲	100
St.Petersburg	10.9		5	●	520
Yaroslavl	6.7		4	▲	42
Krasnodar	6.7		5	▲	51
Kaliningrad	6.4		3	▼	27
Oslo	5.8	1997	6	▲	28
Gdansk	4.1		8	▼	31
Stockholm	3.3	1996	6	●	23
Varna	1.6	1997	4	▲	5
Bratislava	1.3	1997	3	▲	6
Copenhagen	1.1	1997	1		5
Prague	0.9	1997	2		11
Malta	0.5	1997	1		2
Geneva	0.3	1997	7	●	1
Ljubljana	0.0	1996	6	●	0

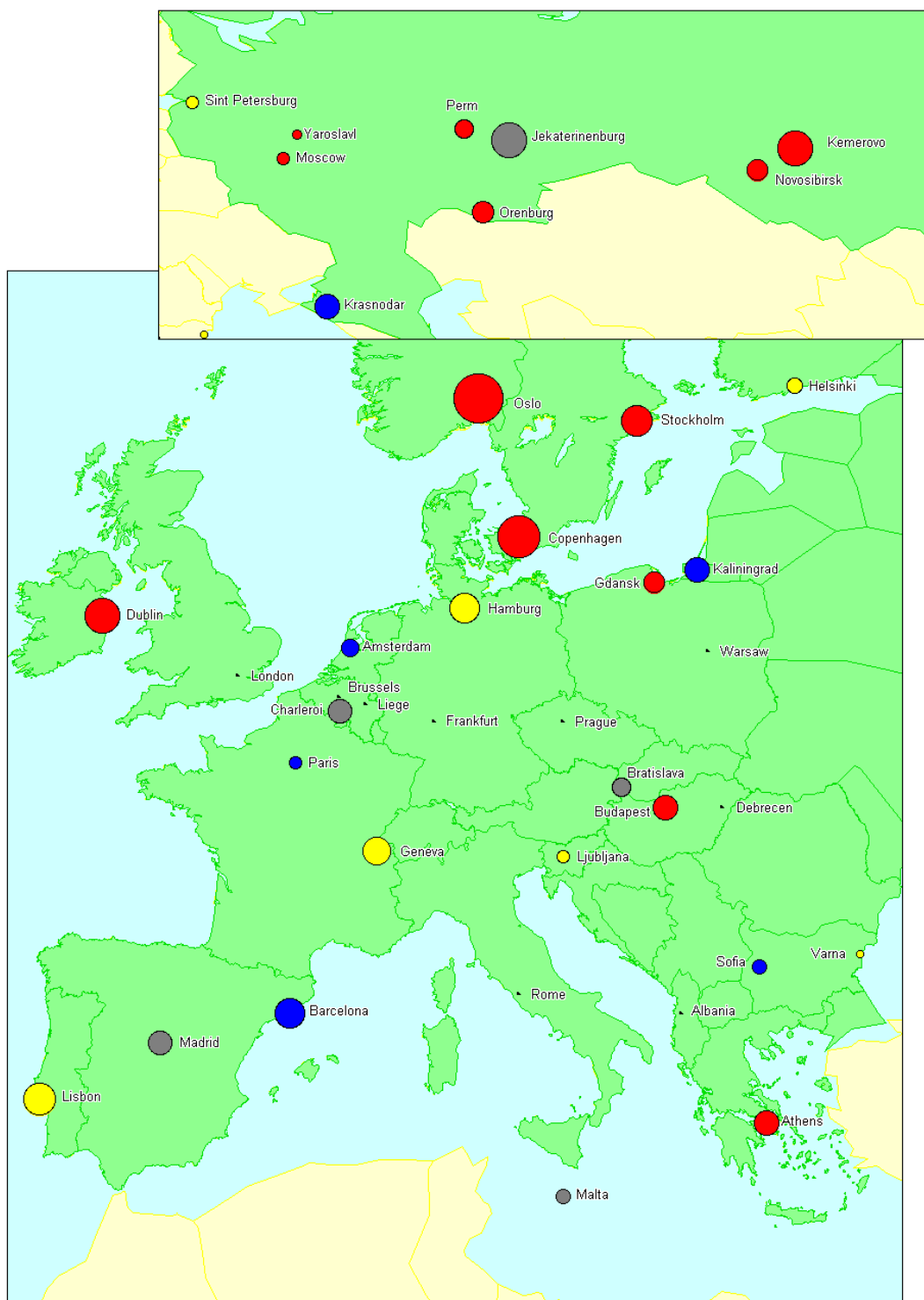
Incidence of AIDS among IDU per 100.000 of population				trend	N of cases
Lisbon	12.4		6	▲	228
Barcelona	10.3	1997	7	●	162
Perm	6.1		2		21
Geneva	5.6	1997	7	●	22
Krasnodar	4.0		5	▲	31
Paris	3.6	1997	7	●	77
Stockholm	2.7	1996	6	●	19
Amsterdam	1.4		8	●	10
Kemerovo	1.4		3	●	7
Gdansk	1.3		8	▲	10
Novosibirsk	1.3		3	▲	18
Copenhagen	1.1	1997	7	●	5
Oslo	0.8	1997	6	●	4
Yaroslavl	0.8		2		5
Ljubljana	0.6	1997	7	▲	2
Warsaw	0.6	1996	6	●	9
Hamburg	0.5	1996	4	●	9
Kaliningrad	0.5		3	▲	2
Moscow	0.2		1		17
St.Petersburg	0.1	1996	2		7
Athens	0.1		2		3
Bratislava	0.0	1997	3	●	0
Malta	0.0	1997	1		0
Prague	0.0	1997	4	●	0
Varna	0.0	1997	4	●	0



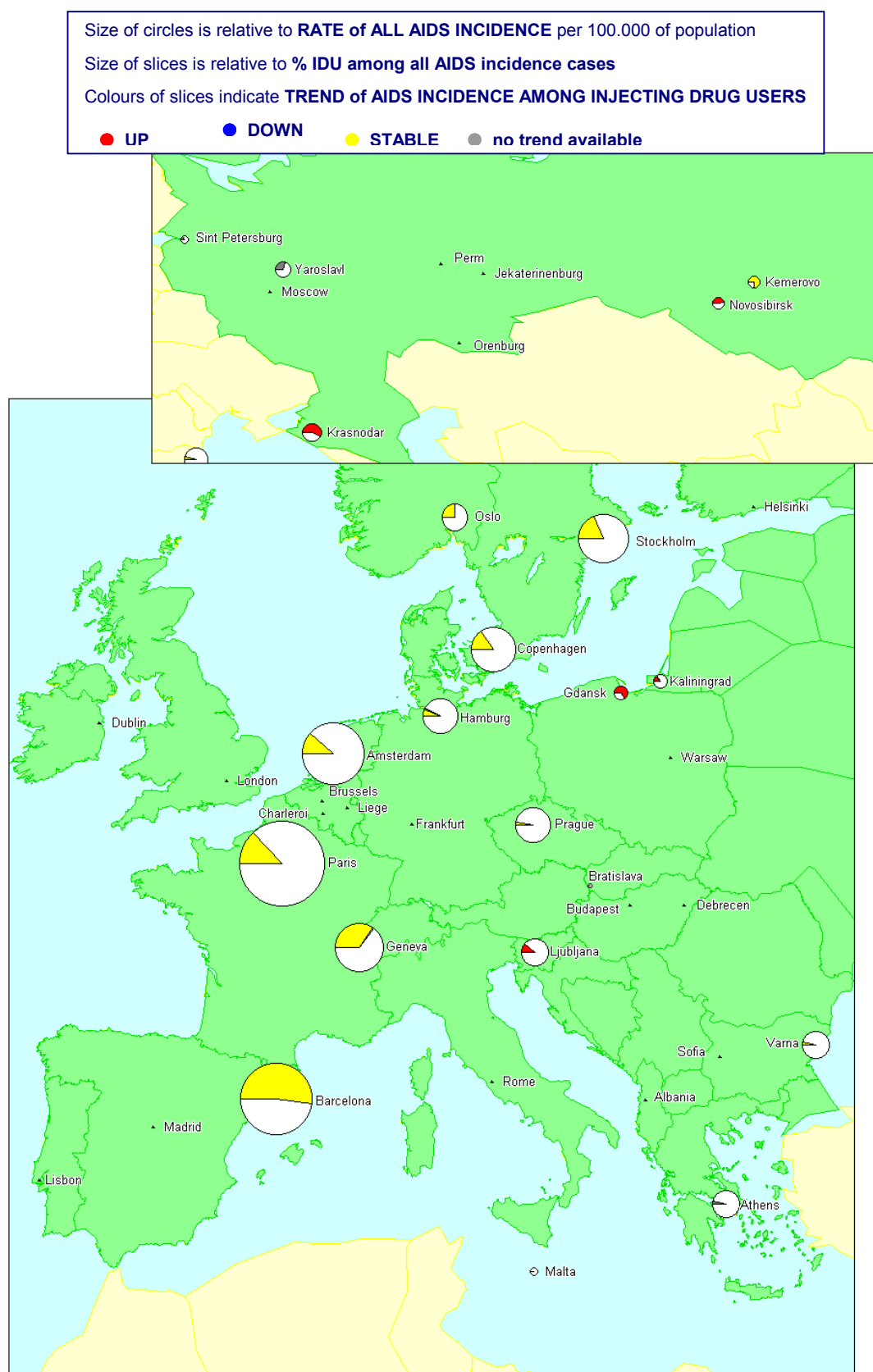
## Drug related deaths

Size of circles is relative to **RATE of DRUG RELATED DEATHS** per 100.000 of population  
Colours of circles indicate **TREND in DRUG RELATED DEATHS**

● **UP** ● **DOWN** ● **STABLE** ● **no trend available**



## Drug related incidence of AIDS



## DRUG LAW OFFENCES

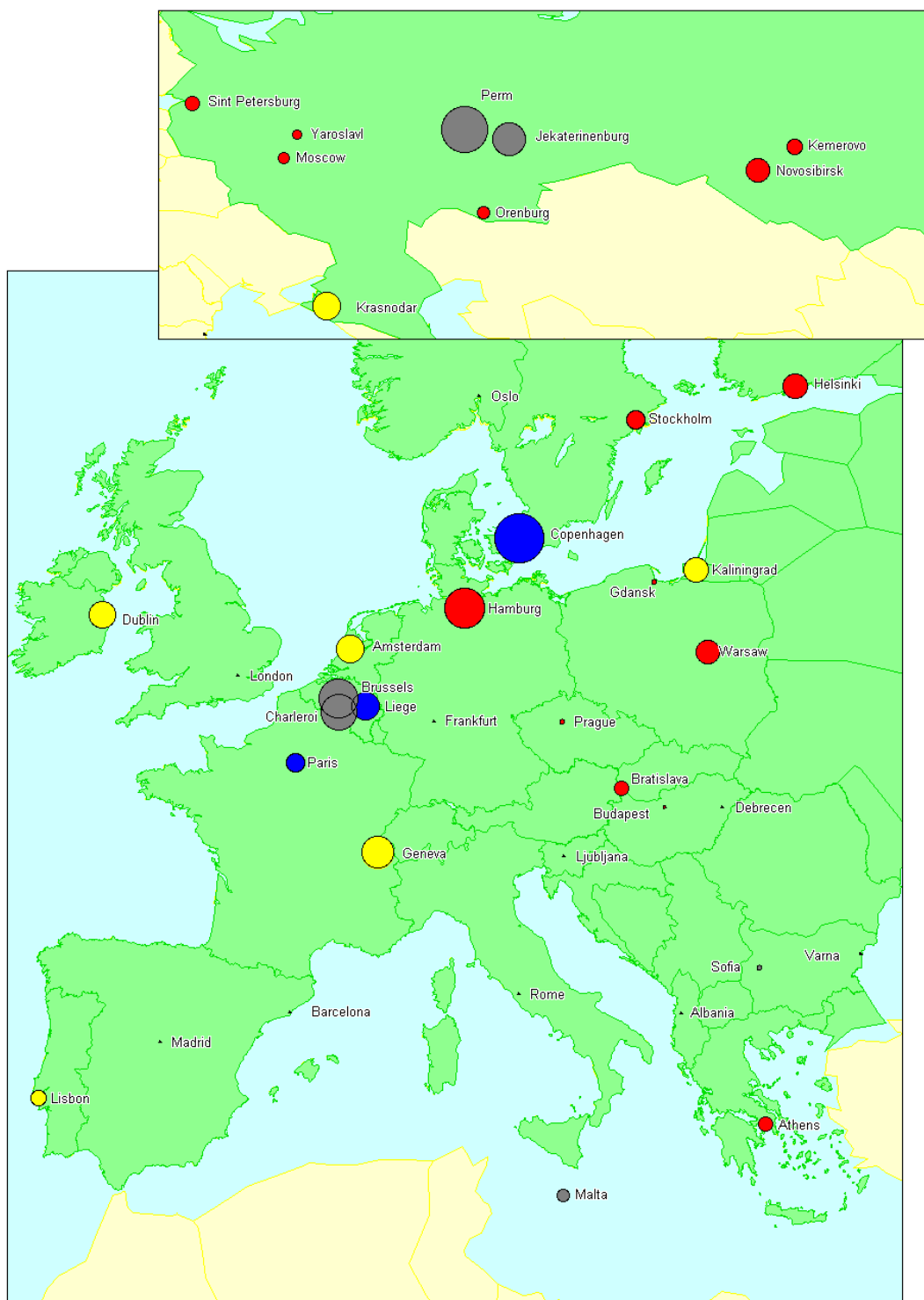
Arrests for drug law offences per 100.000 of population					trend	Arrests for drug use	Arrests related to cannabis
						trend	trend
Copenhagen	1247	1997	7		▼	▼	
Perm	883		1				
Hamburg	780	1997	5		▲	▲	▲
Brussels	653	1997	1				
Charleroi	583		1				
Jekaterinburg	481		1				
Geneva	464	1996	4		●	●	●
Amsterdam	391		8		●	▼	●
Helsinki	365		8		▲		▲
Liege	361	1996	4		▼		
Novosibirsk	351		4		▲	▲	
Dublin	321		7		●	●	
Warsaw	281	1996	5		▲		
Kaliningrad	263		3		●	▼	▲
Krasnodar	235		5		●	●	▲
Kemerovo	223	1997	3		▲		
Stockholm	192	1996	5		▲	▲	●
St.Petersburg	184		5		▲	▲	▲
Paris	176		8		▼	▼	●
Athens	149	1997	7		▲		
Orenburg	147		4		▲		▲
Malta	122	1999	3		▲	▲	▲
Yaroslavl	118		5		▲	▲	
Lisbon	114		8		●	●	
Bratislava	110	1997	4		▲	▲	
Moscow	95		4		▲	▲	▲
Gdansk	25		8		▲	▲	●
Prague	23	1997	6		▲		
Sofia	21		1				
Budapest	15	1997	7		▲		▲
Varna	7	1997	4		●	▼	

Convictions for drug law offences per 100.000 of population				trend
Perm	557		4	▲
Oslo	431	1997	1	
Stockholm	247	1996	6	●
Novosibirsk	245		5	▲
Krasnodar	235		5	▲
Amsterdam	124	1996	6	●
Orenburg	119		5	▲
Kaliningrad	119		3	▲
Jekaterinburg	117		1	
St.Petersburg	111		5	▲
Bratislava	111		6	▲
Kemerovo	108	1997	3	▲
Geneva	100	1996	6	●
Moscow	89		1	
Hamburg	80	1996	5	▼
Paris	76		8	▼
Lisbon	59		8	▲
Yaroslavl	47		2	
Gdansk	8		8	●
Prague	7	1997	6	▲
Sofia	6	1997	1	
Budapest	3		6	●
Varna	3	1997	4	▲
Warsaw	2	1997	7	▲

## Total arrests for drug law offences

Size of circles is relative to **RATE of ARRESTS for DRUG LAW OFFENCES** per 100.000 of population  
Colours of circles indicate **TREND in ARREST for DRUG LAW OFFENCES**

● **UP** ● **DOWN** ● **STABLE** ● **no trend available**



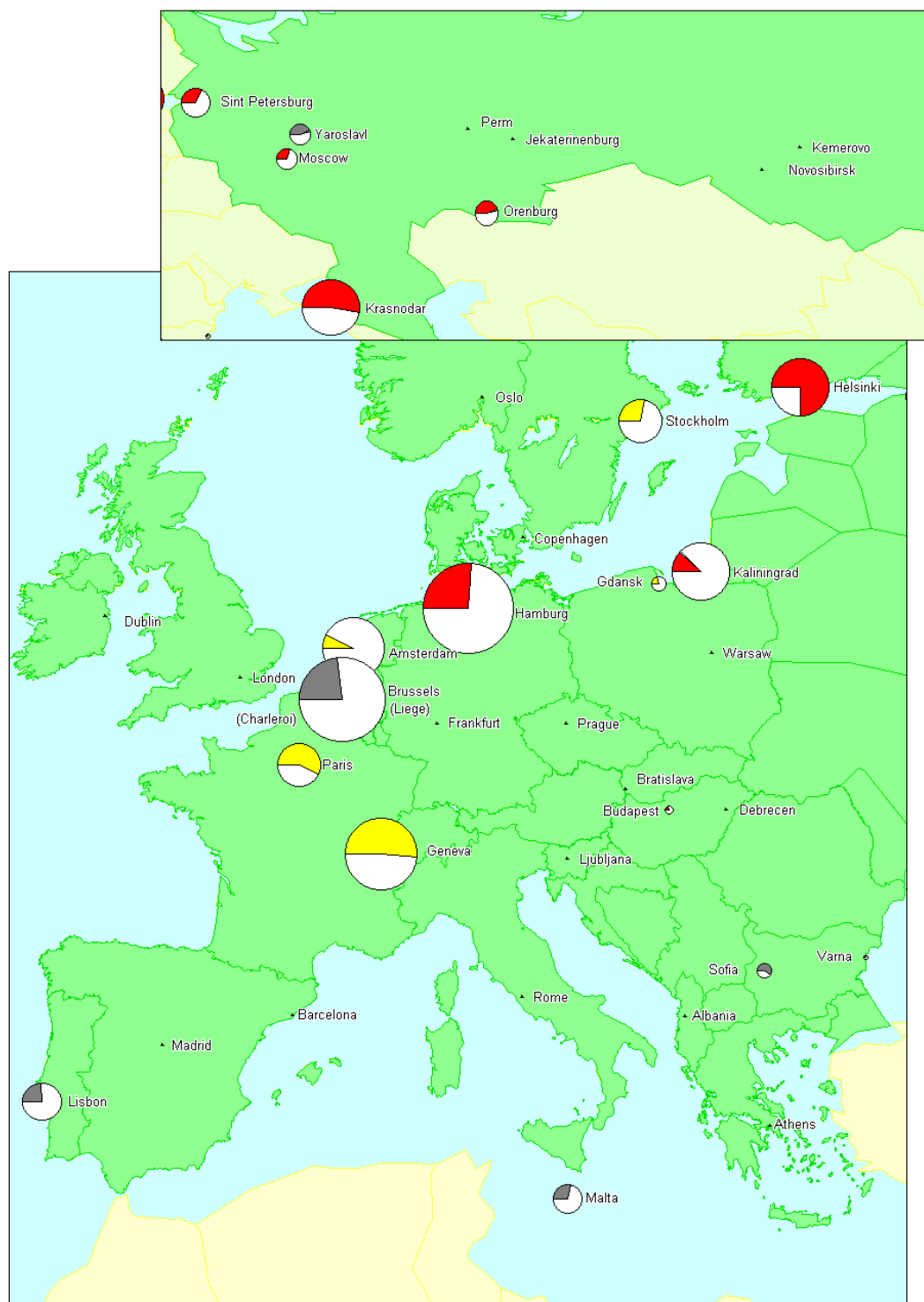
## Arrests for drug law offences related to cannabis

Size of circles is relative to **RATE of ARRESTS for DRUG LAW OFFENCES** per 100.000 of population

Size of slices is relative to **% CANNABIS RELATED** among all arrests for drug law offences

Colours of slices indicate **TREND in CANNABIS RELATED ARRESTS**:

● **UP**      ● **DOWN**      ● **STABLE**      ● **no trend available**



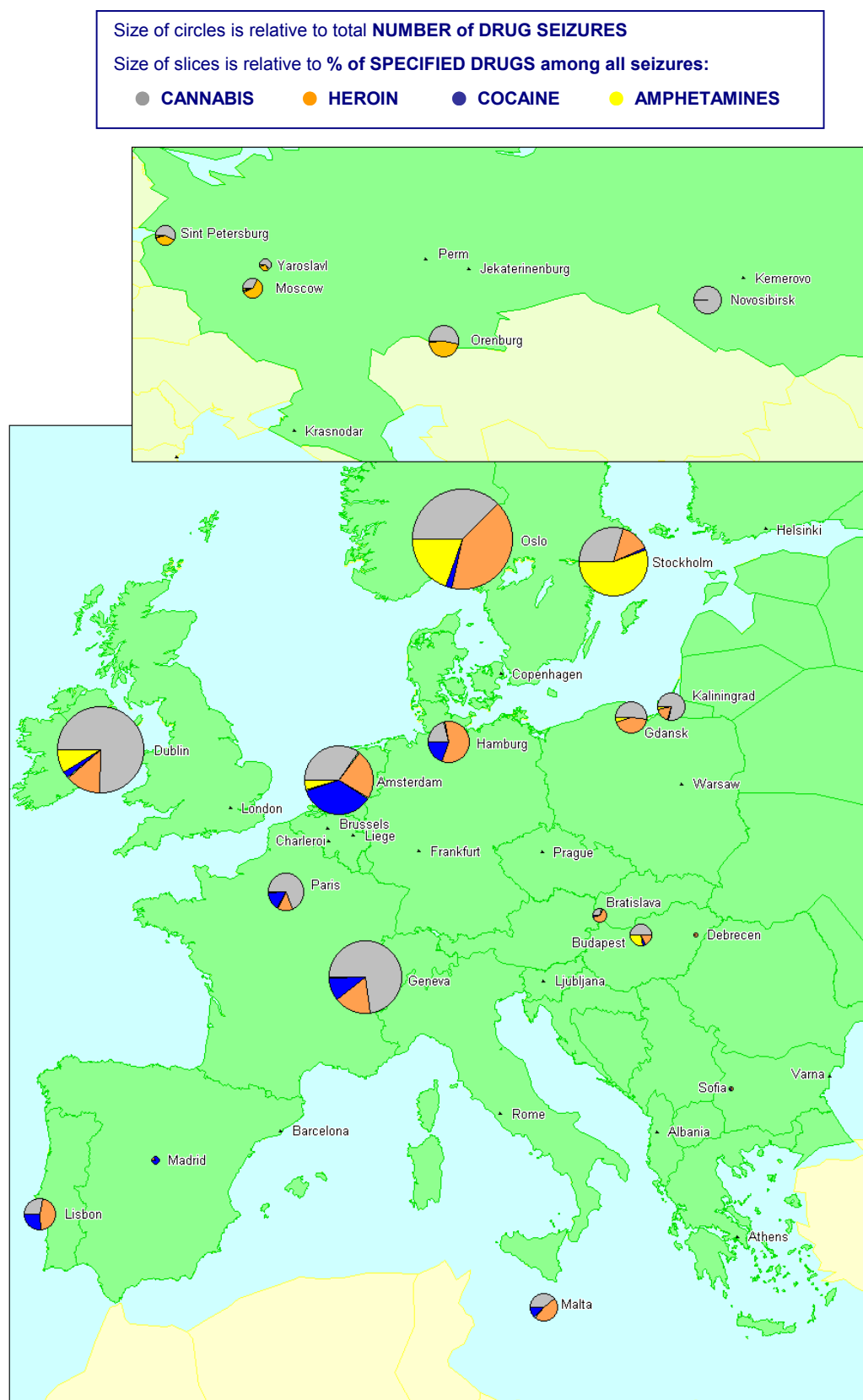
## DRUGS MARKET

	Trends in numbers of drug seizures				Trends in amounts of drugs seized			
	Cannabis	Heroin	Cocaine	Amphet.	Cannabis	Heroin	Cocaine	Amphet.
Albania		▲				●		
Amsterdam	▼	●	●	▼	●	●	●	●
Budapest	●	●	●	●				
Dublin	▲	▲	▲	▲	●	▲	●	●
Gdansk	▲	▲	●	▲	●		●	▲
Geneva	●	●	▲	●				
Hamburg	▲	▲	▲					
Kaliningrad	●			▲				
Lisbon	▲	▲	▲		▼	▲	▲	
Malta	●	▼	●	▼	●	●	▲	
Moscow	▲	▲	●	●	●	▲	●	●
Novosibirsk	●				▲			
Orenburg	●				●			
Oslo	●	▲	▲	▲				
Paris	●	▼	●	●				
St.Petersburg	▲	▲	●	●	●	▲	●	●
Stockholm	▼	▼	▼	●				
Yaroslavl	●	▲						

Purity of heroin at street level				trend
Prague	70%	1997	1	
Madrid	50%		1	
Oslo	45%	1997	1	
Amsterdam	40%	1999	4	▼
Gdansk	38%		8	●
Dublin	36%		8	●
St.Petersburg	35%		1	
Budapest	30%		4	▲
Bratislava	18%	1997	1	
Athens	15%	1997	3	●

	Trends in prices of drugs at street level			
	Cannabis	Heroin	Cocaine	Amphet.
Amsterdam	▲	●	●	
Dublin	●	●	●	
Gdansk	●	▲	●	●
Kaliningrad	▲	▼	▼	
Kemerovo	▲	●		
Lisbon	▲	▼	●	
Novosibirsk	▲	▲	▲	
Orenburg	●			
Prague	▼	▼	●	▼
St.Petersburg	▲	▲	▲	▲
Yaroslavl	▼	▼	▲	▼

## Numbers of drug seizures by type of drug



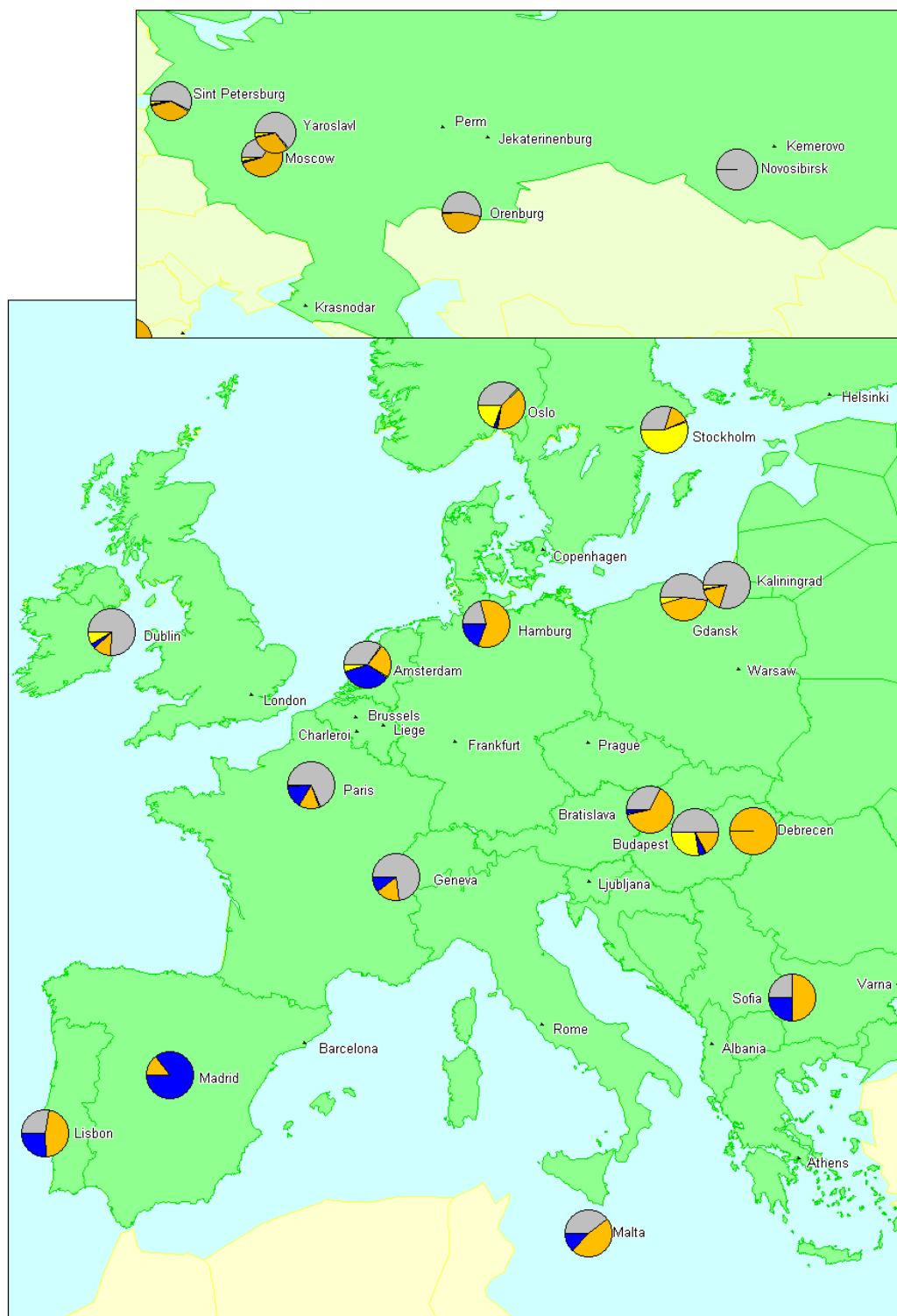


## Drug seizures by type of drug

Size of slices is relative to % of DRUGS among ALL SEIZURES:

● CANNABIS ● HEROIN ● COCAINE ● AMPHETAMINES

NB. All seizures = 100% for each city





## 4.2

# AGGREGATE TRENDS

## (EAST-WEST COMPARISONS)

### ACCOUNT OF DATA PRESENTATION

The previous section already shows that indicator trends of most Eastern European cities differ from those in Western Europe. Such differences can be more easily inspected by aggregating data of individual cities. In this section we compare aggregate trends between Eastern and Western European cities over the period 1991-1998, but the approach could make sense for other groupings of cities as well.

The comparison is based on simple AVERAGES of indicator values across Eastern and Western European cities and presented in two formats.

- *Summary table of recent average indicator values and trends*
- *Graphs showing developments of average indicators values*

Whenever applicable we have taken the RATES per 100.000 of population to calculate the averages. The table gives the most recent figure available. As before the cut-off point for 'recent' is set at 1996, so values prior to that year are not presented. In general the average figures refer to 1998, if not the appropriate year is listed in italics next to a figure.











































Average indicator values in each of the two clusters of cities are only calculated if we have for any year indicator data of at least 4 cities. The summary table lists the number of cities on which the average figure is calculated.

Trends refer to the developments of the average figures in each cluster in the period 1991-1998. Trends have been assessed and labelled as described above in section 4.1. No trends are assessed if we have less than 3 figures for the reporting period for either Eastern or Western Europe.

## SUMMARY OF TRENDS

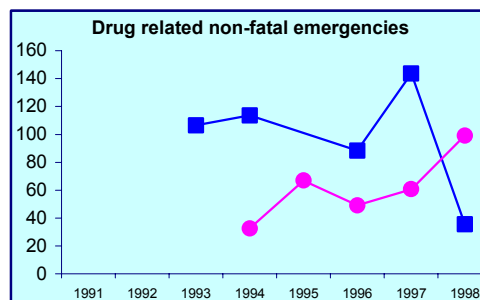
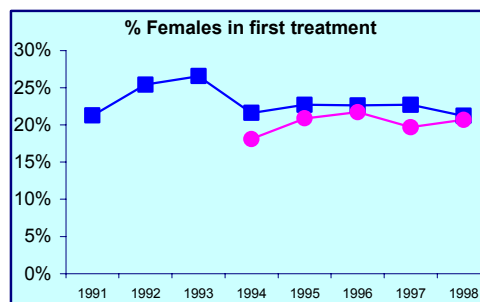
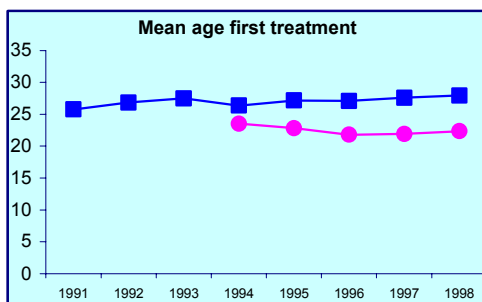
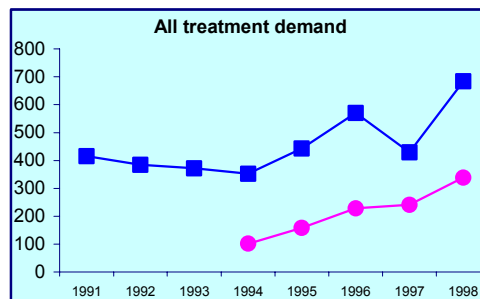
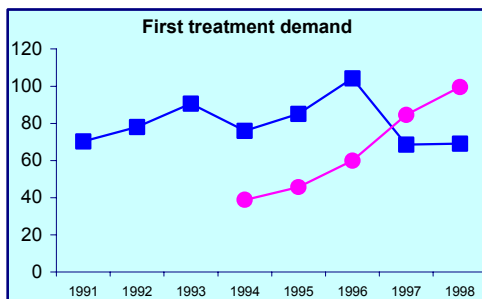
Trend orientation

	UP
	DOWN
	STABLE

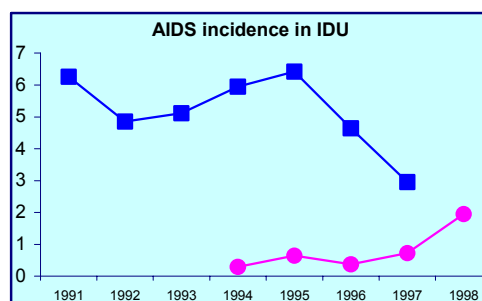
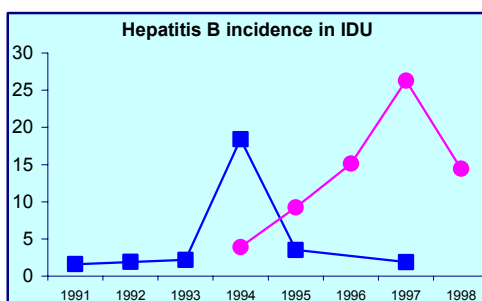
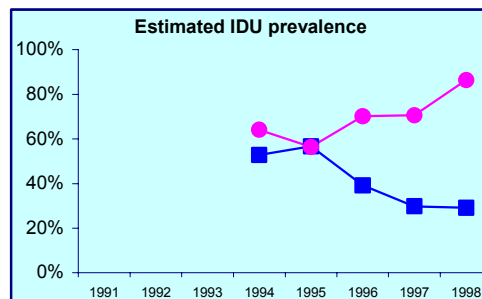
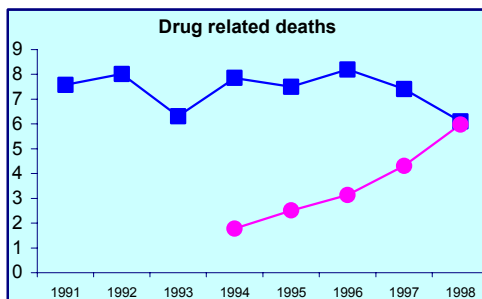
	EASTERN EUROPE				WESTERN EUROPE			
	value	year	no. of cities in average	trend	value	year	no. of cities in average	trend
<b>TREATMENT</b>								
First treatment demand	100		14		69		7	
All treatment demand	339		14		684		6	
Mean age ( <i>first treatment</i> ) *	22.4		7		27.9		5	
% < 25 yrs ( <i>first treatment</i> ) *	60.8%		10		47.5%		5	
% females ( <i>first treatment</i> ) *	20.7%		12		21.2%		5	
Admissions psychiatric hospitals	94		9					
Admissions general hospitals	16		4					
Non-fatal emergencies	99		11		36		4	
<b>HEALTH</b>								
% estimate IDU prevalence *	86.4%		6		29.2%		4	
Drug related deaths	6		12		6		9	
Hepatitis B incidence in IDU	14		8		2	1997	4	
AIDS incidence in IDU	2		8		3	1997	8	
<b>DRUG LAW OFFENCES</b>								
Arrests for traffick offences	74		9		98		7	
Arrests for drug use offences	173		6		172		6	
Arrests for any drug law offence	255		11		296		7	
Cannabis related arrests	34		6		107		4	
Convictions drug law offences	147		12		116	1996	6	
<b>DRUGS MARKET</b>								
Cannabis seizures	36		9		125		5	
Heroin seizures	38		9		37		5	
Cocaine seizures	1		8		15		5	
Amphetamines seizures	6		8		19		4	
Total drug seizures	97		9		204		5	

NB.: Average indicator values are RATES per 100.000 of population except those marked with \*

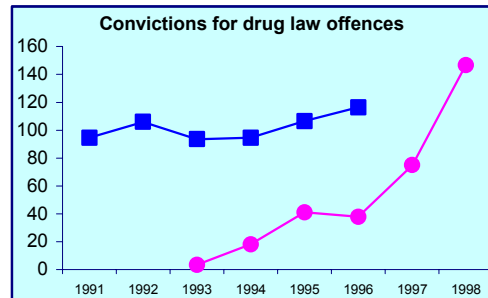
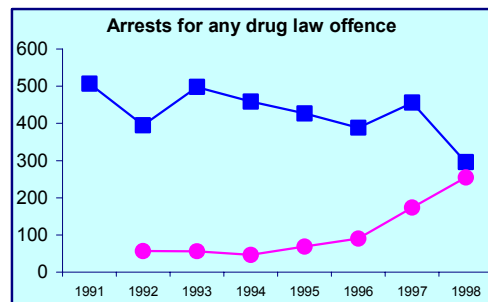
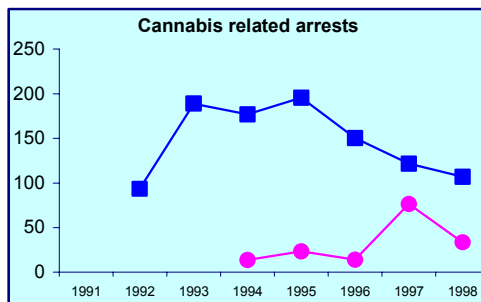
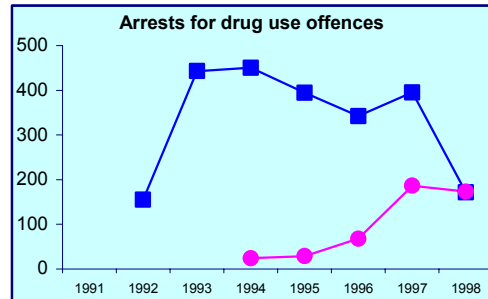
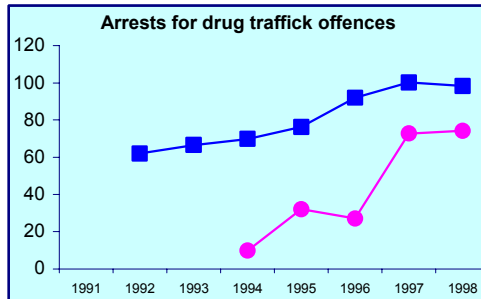
# TREATMENT



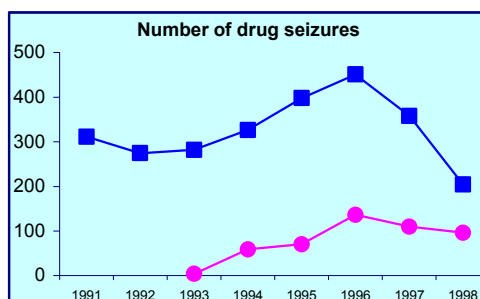
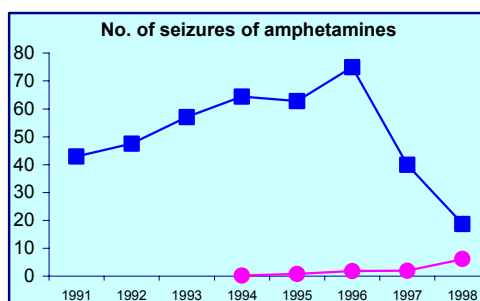
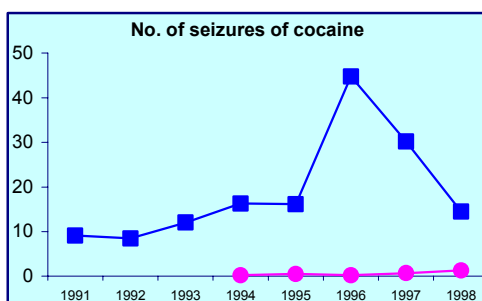
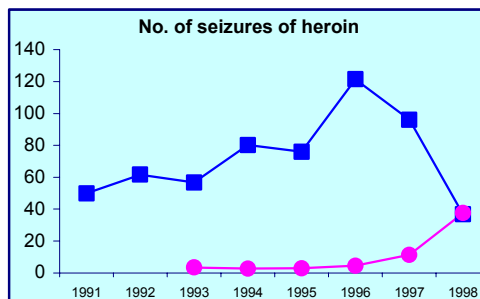
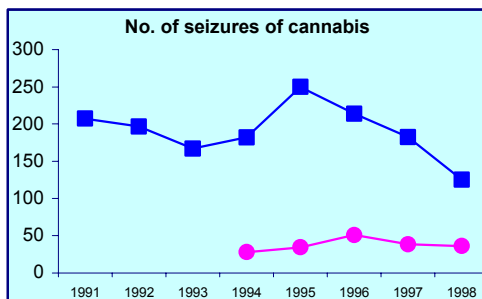
# HEALTH



## DRUG LAW OFFENCES



# DRUGS MARKET









# ANALYSIS AND INTERPRETATION



# 5.1

## ANALYSIS

### (RELATIONS BETWEEN INDICATORS)

#### METHODS OF ANALYSIS

The data collection of the Multicity network has been used in the past almost exclusively for descriptive purposes. Sections 3 and 4 of this report follow this trend. The descriptions of data and trends not only reveal substantial differences between European cities but also suggest many parallel trend developments in individual indicators.

Previous reports of the Epidemiology Group have been largely restricted to interpretations of trends and comparisons of cities on a face-value basis. From a scientific point of view this is not very satisfying and with the growing number of cities in the network the approach becomes almost an impossible task too. In the framework of the 3<sup>rd</sup> Multicity Study we therefore attempt to a statistical analysis of European patterns in drug problems by taking the Multicity data collection as a convenient sample of cities to assess interrelations between indicators and to classify cities by common patterns of indicator trends

The analysis has been carried out on the database constructed after the collection of 1997 data. This not only implies that the more recent data of 1998 are not included, but also that corrections on and additions to previous data, which have been delivered by some cities together with the 1998 city data are not accounted for. Moreover, the analysis has been carried out on absolute figures of indicator data, not on figures standardised to rates per number of population.

The analysis is primarily intended as an **example exercise in exploration** of patterns, illustrating the analytical potential of the Multicity database. For this reason we have not repeated the exercise on the updated database.

The dataset 1991-1997 consists of 146 variables, covering 34 cities. However, the majority of these variables could not be included in the process of statistical analyses because of the large number of missing values. Moreover, eight cities had to be excluded completely from the analysis because their very high number of missing values. For the analysis we could select 32 variables of 26 cities (12 in Western and 14 in Eastern Europe) for 7 years (1991-1997), which means that we have for each variable a maximum of  $26 \times 7 = 182$  cases. Not one variable however provides more than 75% valid cases and only 10 variables have more than 50% valid cases.

In order to improve the potential for analysis, some 200 missing values in time series of variables have been imputed by calculated values if we had at least data for five years and these data showed a clear up- or downward trend. In such cases missing data have been replaced by the average of the known data from the preceding and following year or by the average of the known data of two preceding or following years. The procedure increased the average number of valid cases up to 43%. Even with this replacement of missing values, the dataset still looks like a Swiss cheese, or the negative image of a Swiss cheese, depending on one's optimism.

Nevertheless, the remaining variables are nicely distributed over the key areas of indicator data of the Multicity network. Though we cannot include the key area of drug prevalence, the available data should allow a reasonable impression of the drug situation in the network.

### ***Relations between indicators***

Relations between different indicators have been explored by calculating correlations based on *Pearson's r*. This might not be the most powerful statistical technique, but it is a common method for a first exploration of interrelations between data. Besides, the quality of the Multicity database at present does not justify higher levels of analysis.

Indicators have been grouped into the categories of treatment (including characteristics of the treated population), health, drug law offences and drugs market. Pearson's *r* has been calculated within indicator groups (intra-group correlations) and between groups (inter-group correlations). Pearson's *r* correlation matrices are commonly used to develop hypotheses about the nature of interrelations between data. As we intend our exercises to be examples to encourage others to continue on more in-depth analysis, we include the results of the correlation analysis in this report. The figures presented in this report are reduced to those variables that show at least one significant correlation with another variable.

The analysis has also been carried out for Eastern and Western European cities separately, which reveals that several relations only exist in one of these regions. In the presentation of results we only give an overview of the most explicit differences in interrelations.

### ***Classification of cities***

The differences between Eastern and Western Europe with regard to average indicator values, trend developments and the strength of relations between indicators, suggest that this regional aspect might be an important factor to explain differences in local drug use situations.

Based on literature we also expect that city size could be an important discriminating factor. For this reason we added city size to our explorations of the Multicity dataset, whereby we reduced this aspect to an arbitrary simple dichotomy of 14 cities above and 12 below 1 million inhabitants.

We tested both dichotomies in an analysis of variance and a multiple classification analysis, both for the whole time span 1991-1997, as well as for the individual years 1996 and 1997 to check the stability of the identified differences. The results are presented in table format. The  $\text{Eta}^2$  values of the multiple classification analysis indicate the percentage of variance in the indicator explained by either the East-West or the City Size factor.

For the orientation of the differences on each variable in the East-West comparison we refer to the tables in Section 4.2. It should be noted however that these tables refer to 1998 data, which have not been included in the tests, and give in most cases averages of variables standardised to rates per 100.000, whereas the tests have been conducted on the absolute indicator values. Information on the orientation of differences in the city size comparison is not provided in this report.

## **RELATIONS WITHIN INDICATOR CATEGORIES**

### ***Treatment***

All treatment demand correlates positively with first treatment demand. When more people enter treatment, the total number of people in treatment increases. This might not surprise at first sight, but actually also implies that inflow exceeds outflow. Both first and all treatment demand correlate positively with heroin users in treatment, which reflects the main orientation of most treatment centres.

Correlation between admissions to psychiatric hospitals and treatment demand might be partially caused by overlap in data collection when psychiatric hospitals include drug treatment units.

### *Health*

As could be expected incidence of Hepatitis B and drug related deaths correlate with injecting drug use as a major health risk factor. The absence of a relationship between injecting and drug related Aids incidence might be due to the relative recent emergence of intravenous drug use in most cities compared to the slow rate of sero-conversion of HIV into Aids. At present we do not have information on HIV incidence as the Multicity network only collects these data since 1997.

### *Drug law offences*

It might not surprise that arrests and convictions are interrelated. Both apparently measure law enforcement in more or less the same way. Although not shown in the correlation matrices below, we also found that convictions for drug law offences go parallel to the total number of convictions for any crime, which indicates that the workload of the courts depends highly on the amount of drug law offences.

### *Market indicators*

Increasing seizures of one drug match increasing seizures of another. This could suggest that in most cities drugs markets are not separated, i.e. traffickers deal in all drugs, but it could also indicate that active law enforcement does not discriminate between different drugs.

## **RELATIONS BETWEEN INDICATOR CATEGORIES**

### *Treatment and health*

There are strong relations between treatment and health indicators related to (consequences) of risk behaviour. This might be obvious by the choice of health indicators and the main orientation of treatment towards injecting heroin use. On the other hand, we have to realise that most health indicator data originate from treatment settings (e.g. incidences of Hepatitis B and Aids refer to people in treatment), so the indicators might be interdependent. We also find several negative correlations between treatment and health indicators. Their interpretation might require more detailed data about drug use patterns and other characteristics of the treated population.

### *Treatment and drug law offences*

Trends in the number of arrests for trafficking and convictions for drug law offences run parallel to trends in the number of clients in first treatment. Treatment and drug law offences both seem to measure the size of the drug problem independently. There might be interdependence as well, e.g. if heroin users are a special target group for law enforcement and if arrested drug users choose treatment to avoid imprisonment. The relation then suggests that law enforcement is an important catchment system for treatment.

### *Treatment and drugs market*

Both seizures of heroin and cocaine correlate with treatment indicators. As market indicators the numbers of drug seizures might indicate either a growing market or a (temporary) scarcity of substances on the market. In both cases the drugs market has an effect on treatment demand.

### *Health, drug law offences and drugs market*

The correlations between health, drug law offences and drugs market indicators point at the impact of legal control on the health situation of drug users. Our findings confirm the relation between drug deaths and seizures, which has been previously explored in the Multicity network by Lenke and Olsson.

### *Drug law offences and drugs market*

Finally, drug law offences and market indicators are highly interrelated, which could be expected, as by nature most drug law offences will imply some confiscation of the drugs involved.

Our findings suggest that all groups of indicators measure the magnitude of the drug problem, in particular with regard to heroin use and injecting drug use. However, as we already remarked above, interdependence between indicators and categories cannot be excluded.

## INTRA-GROUP CORRELATIONS

0.61 positive significant correlation  
-0.25 negative significant correlation

TREATMENT	First treatment	All treatment	Mean age (FTD)	% females (FTD)	% < 25 yrs (FTD)	% Cann. users (FTD)	Heroin users (FTD)	% heroin users (FTD)	Admiss. psychiatr. hospitals	Admiss. general hospitals	Non-fatal emergencies
First treatment demand (FTD)											
All treatment demand (ATD)	0.61										
Mean age (first treatment)											
% females (first treatment)		-0.25									
% < 25 yrs (first treatment)			-0.59								
% cannabis users (first treatment)	-0.33	-0.34			-0.37						
Heroin users (first treatment)	0.71	0.58				-0.39					
% heroin users (first treatment)		-0.40		0.27							
Admissions to psychiatric hospitals	0.87	0.80	0.30					-0.42			
Admissions to general hospitals	0.44	0.46					0.92				
Non-fatal emergencies	0.45	0.29			-0.35	-0.39	0.85		0.66	0.48	

HEALTH	Hep. B (IDU)	AIDS (IDU)	Drug deaths	% IDU (FTD)	% IDU (ATD)
Incidence of Hepatitis B in IDU					
Incidence of AIDS in IDU					
Drug related deaths		0.37			
% IDU (first treatment)	0.64				
% IDU (all treatment)	0.67		0.43	0.85	

DRUG LAW OFFENCES	Traffick arrests	Total DLO arrests	Total DLO convict.	Prison sentence
Arrests for drug trafficking offences				
Arrests any drug law offences (DLO)	0.76			
Convictions drug law offences	0.30	0.87		
Prison sentences for DLO			0.48	

DRUGS MARKET	Cannabis seizures	Heroin seizures	Cocaine seizures	Amphet. seizures
Cannabis seizures				
Heroin seizures	0.42			
Cocaine seizures	0.88	0.44		
Amphetamine seizures	0.68	0.30	0.55	

## INTER-GROUP CORRELATIONS

TREATMENT / HEALTH	Hep. B (IDU)	AIDS (IDU)	Drug deaths	% IDU (FTD)	% IDU (ATD)
First treatment demand (FTD)	0.40		0.56	0.52	0.37
All treatment demand (ATD)	0.51	0.22	0.34	0.52	0.39
Mean age (first treatment)				-0.42	
% females (first treatment)		-0.30			
% < 25 yrs (first treatment)			-0.34	0.51	0.42
% cannabis users (first treatment)	-0.58	-0.41		-0.36	
Heroin users (first treatment)		0.60	0.61		
% heroin users (first treatment)	-0.74	-0.46		-0.30	-0.31
Admissions to psychiatric hospitals	0.66		0.63	0.75	0.69
Admissions to general hospitals			0.26		
Non-fatal emergencies	0.35	0.50	0.87		



<b>TREATMENT / DRUG LAW OFFENCES</b>	Traffic arrests	Total DLO arrests	Total DLO convict.	Prison sentence
First treatment demand (FTD)	0.59	0.44	0.36	
All treatment demand (ATD)	0.47			
Mean age (first treatment)			0.41	0.47
% females (first treatment)	0.38			
% < 25 yrs (first treatment)		-0.43	-0.33	
% cannabis users (first treatment)				
Heroin users (first treatment)	0.62			0.69
% heroin users (first treatment)			-0.34	
Admissions to psychiatric hospitals			0.59	
Admissions to general hospitals	0.55		0.28	0.43
Non-fatal emergencies	0.53	0.41		

<b>TREATMENT / DRUGS MARKET</b>	Cannabis seizures	Heroin seizures	Cocaine seizures	Amphet. seizures
First treatment demand (FTD)		0.50		
All treatment demand (ATD)				
Mean age (first treatment)			0.55	
% females (first treatment)		0.34		
% < 25 yrs (first treatment)		-0.47		-0.57
% cannabis users (first treatment)		0.82	0.94	
Heroin users (first treatment)		0.68	0.81	
% heroin users (first treatment)		0.45		
Admissions to psychiatric hospitals	0.42			0.90
Admissions to general hospitals		0.59	0.57	
Non-fatal emergencies				

<b>HEALTH / DRUG LAW OFFENCES</b>	Traffic arrests	Total DLO arrests	Total DLO convict.	Prison sentence
Incidence of Hepatitis B in IDU			0.43	-0.44
Incidence of AIDS in IDU				
Drug related deaths	0.69	0.68	0.41	0.39
% IDU (first treatment)	0.57	0.46	0.52	
% IDU (all treatment)	0.60		0.42	

<b>HEALTH / DRUGS MARKET</b>	Cannabis seizures	Heroin seizures	Cocaine seizures	Amphet. seizures
Incidence of Hepatitis B in IDU		-0.38		
Incidence of AIDS in IDU				
Drug related deaths	0.49	0.50	0.25	
% IDU (first treatment)				
% IDU (all treatment)				

<b>DRUG LAW OFFENCES / DRUGS MARKET</b>	Cannabis seizures	Heroin seizures	Cocaine seizures	Amphet. seizures
Arrests for drug trafficking offences	0.55	0.45	0.40	
Arrests any drug law offences (DLO)	0.95	0.65	0.79	0.47
Convictions drug law offences	0.96	0.58	0.80	0.93
Prison sentences for DLO	0.98	0.43	0.87	0.99
Convictions drug offences	0.92	0.47	0.78	0.76
DLO prison sentences	0.36	0.50	0.34	

## EAST-WEST DIFFERENCES

The relations between individual indicators have also been explored for Eastern and Western European cities separately. Although most relations can be found both in the West and in the East, several relationships only exist in one of the regions and often there are clear differences in the strength of the relations. We present the results in a table listing those relations, which only exist in either Western Europe or Eastern Europe or which show an opposite orientation of the relation in these regions. The table only lists significant correlations with an  $r$ -value  $> 0.70$ .

The East-West distinction has also been tested in a multiple classification analysis. The results are presented in a table of  $\text{Eta}^2$  values of each indicator for the whole time span 1991-1997. Any significant  $\text{Eta}^2 > 0.10$  means that the East-West factor adds to the explanation of the variance in the indicator. Significant  $\text{Eta}^2$  values for the single years 1996 and 1997 indicate consistency. The table also presents the significance of interaction effects between the East-West and the City Size factor.

### *Eastern Europe*

In contrast to Western Europe increase in all treatment does not correlate with increase in the proportion of heroin users in first treatment. This might be an effect of the recent switch from the traditional use of homemade opiates to heroin. Eastern European cities show strong relations between treatment indicators at one hand and drug law offences and drugs market indicators at the other. The strong Western European relations between the proportions of heroin and injecting users in first treatment with law enforcement and market indicators do not exist.

The highest variances explained by the East-West factor refer to the proportion of young clients in first treatment, non-fatal emergencies, drug deaths and prison sentences for drug law offences.

### *Western Europe*

The high correlation between all treatment and the proportion of heroin users in first treatment reflects the main target population of treatment services or the development of more long-term substitution programmes within treatment. Unlike in Eastern Europe we find strong positive correlations between heroin use, IDU and drug related morbidity with arrests and seizures.

In Western European cities, increasing mean age of first clients in treatment correlates negatively with non-fatal emergencies. The interpretation could be, that older users are more experienced users and experience reduces risk behaviour. Alternative to this “social maturation explanation” we might also consider a “Darwinist explanation”: younger users either quitted or died and the remaining older users are more resistant to risks. However, differences in drug policy, e.g. formal versus informal social control, could play a significant role as well.

## CITY SIZE DIFFERENCES

The factor City Size has only been explored in a multiple classification analysis. Most high  $\text{Eta}^2$  values on the City Size factor should not be surprising as many indicators relate to problem drug use, which in general is a typical metropolitan issue. The highest variances explained by City Size we find for non-fatal emergencies, incidence of Hepatitis B in IDU, drug related deaths and arrests related to trafficking. The relative low  $\text{Eta}^2$  values for city size with regard to drug seizures might indicate that seizures are not so much related to the local drug situation, but to other city attributes, like geographical location on international drug trade routes.

## EAST-WEST DIFFERENCES IN INDICATOR RELATIONS

.84 positive correlation  
-.82 negative correlation

	Indicator relations	WEST	EAST
TREATMENT	All treatment demand - % heroin users (first treatment)	.84	
	All treatment demand – Admissions to psychiatric hospitals		.86
	All treatment demand – non-fatal emergencies	-.82	.52
	Mean age (first treatment) - % aged < 25 (first treatment)	-.97	
	Mean age (first treatment) - % IDU (first treatment)		.77
	Mean age (first treatment) - Non-fatal emergencies	-.82	
	% females (first treatment) - Admissions to psychiatric hospitals	.80	
	% Cannabis users (first treatment) - non-fatal emergencies	-.87	
	% heroin users (first treatment) – Admissions to psychiatric hospitals	.91	-.54
	% heroin users (first treatment) – Admissions to general hospitals		-.93
	% heroin users (first treatment) - Non-fatal emergencies		-.84
DRUG LAW OFFENCES DRUGS MARKET	Arrests for any drug law offence - Prison sentences for drug law offences		.87
	Arrests for any drug law offence - Seizures of cocaine	.76	
	Convictions for drug law offences - Seizures of heroin	.39	
	Convictions for drug law offences - Seizures of cocaine	.78	
TREATMENT HEALTH	All treatment demand - Drug related deaths		.84
	Non-fatal emergencies - Incidence of AIDS in IDU	.85	-.21
	% Cannabis users (first treatment) - Incidence of AIDS in IDU	-.86	
	%IDU (first treatment) – Admissions to psychiatric hospitals		.73
	%IDU (first treatment) – Admissions to general hospitals	-.91	
	%IDU (first treatment) - Non-fatal emergencies	-.78	.65
	%IDU (all treatment) – Admissions to general hospitals	-.99	.44
TREATMENT DRUG LAW OFFENCES DRUGS MARKET	First treatment demand – Seizures of cocaine		.85
	First treatment demand – Seizures of amphetamines		.80
	All treatment demand – Arrests for any drug law offence		.72
	All treatment demand – Convictions for drug law offences		.71
	All treatment demand – Seizures of heroin		.77
	All treatment demand – Seizures of cocaine		.76
	All treatment demand – Seizures of amphetamines		.72
	Admissions to psychiatric hospitals – Convictions for drug law offences		.73
	Admissions to psychiatric hospitals – Seizures of heroin		.94
	Admissions to psychiatric hospitals – Seizures of cocaine		.93
	Admissions to psychiatric hospitals – Seizures of amphetamines		.91
	Admissions to general hospitals – Arrests for drug trafficking offences		.83
	Admissions to general hospitals – Prison sentences for drug law offences		-.74
	Non-fatal emergencies – Arrests for any drug law offence		.69
	Heroin users (first treatment) - Arrests for drug trafficking offences	.82	
	Heroin users (first treatment) – Prison sentences for drug law offences	.81	
	% heroin users (first treatment) – Arrests for drug trafficking offences		-.77
	% heroin users (first treatment) – Arrests for any drug law offence		-.70
	% heroin users (first treatment) – Prison sentences for drug law offences	-.93	
HEALTH DRUG LAW OFFENCES DRUGS MARKET	Incidence of Hepatitis B in IDU - Arrests for any drug law offence	.79	
	Incidence of Hepatitis B in IDU - Seizures of amphetamines	.74	
	Incidence of AIDS in IDU - Prison sentences for drug law offences	.95	
	Drug related deaths – Seizures of cocaine		.76
	Drug related deaths - Seizures of amphetamines		.80
	% IDU (first treatment) – Arrests for drug trafficking offences	.88	
	% IDU (all treatment) – Arrests for any drug law offence	.92	
	% IDU (first treatment) – Arrests for any drug law offence		.94
	% IDU (first treatment) – Seizures of heroin	.80	
	% IDU (first treatment) – Seizures of cocaine	.95	

## IMPORTANCE OF EAST-WEST FACTOR ON INDICATOR VARIANCE

.22    ● significant contribution to variance explanation  
■ significant interaction with City Size

### Results of Analysis of Variance (Hierarchical) / Multiple Classification Analysis

Indicator group	Indicator				interactions with City Size factor	valid cases
		1991-1997	1997	1996		
TREATMENT	First treatment demand	,02				112
	All treatment demand	,05			■	118
	Mean age (first treatment)	,08			■	84
	% Females (first treatment)	,02				104
	% < 25 (first treatment)	,37	●	●		88
	Admissions to psychiatric hospitals	,00				70
	Admissions to general hospitals	,22	●	●	■	64
	Non-Fatal Emergencies	,32	●	●	■	61
	% Cannabis users (first treatment)	,09				47
	% Heroin users (first treatment)	,04		●	■	61
HEALTH	% IDU in first treatment	,12		●		55
	% IDU in all treatment	,06			■	53
	Incidence of Hepatitis B in IDU	,16			■	67
	Incidence of AIDS in IDU	,02			■	96
	Drug related deaths	,31	●	●	■	120
DRUG LAW OFFENCES	Arrests for drug trafficking offences	,15			■	69
	Arrests for any drug law offence	,19				72
	Convictions for drug law offences	,17		●		113
	Prison sentences for DLO	,31	●		■	68
DRUGS MARKET	Seizures of cannabis	,09			■	70
	Seizures of heroin	,24				63
	Seizures of cocaine	,11	●			66
	Seizures of amphetamines	,21				61

## IMPORTANCE OF CITY SIZE FACTOR ON INDICATOR VARIANCE

- .22    ● significant contribution to variance explanation  
■ significant interaction with East-West factor

### Results of Analysis of Variance (Hierarchical) / Multiple Classification Analysis

Indicator group	Indicator	Eta <sup>2</sup> CITY SIZE			interactions with East-West factor	valid cases
		1991-1997	1997	1996		
TREATMENT	First treatment demand	.22	●	●		112
	All treatment demand	.11			■	118
	Mean age (first treatment)	.03			■	84
	% Females (first treatment)	.00				104
	% < 25 (first treatment)	.00				88
	Admissions to psychiatric hospitals	.20				70
	Admissions to general hospitals	.00			■	64
	Non-Fatal Emergencies	.41			■	61
	% Cannabis users (first treatment)	.07				47
	% Heroin users (first treatment)	.14		●	■	61
HEALTH	% IDU in first treatment	.19		●		55
	% IDU in all treatment	.22			■	53
	Incidence of Hepatitis B in IDU	.50	●	●	■	67
	Incidence of AIDS in IDU	.08			■	96
	Drug related deaths	.37	●	●	■	120
DRUG LAW OFFENCES	Arrests for drug trafficking offences	.30			■	69
	Arrests for any drug law offence	.10				72
	Convictions for drug law offences	.05				113
	Prison sentences for DLO	.02			■	68
DRUGS MARKET	Seizures of cannabis	.06			■	70
	Seizures of heroin	.00				63
	Seizures of cocaine	.04				66
	Seizures of amphetamines	.01				61



## 5.2

# INTERPRETATION (EXPERT SURVEY)

## METHODS OF ANALYSIS

In this section we present the results of a survey among the experts of the Epidemiology Group about their perceptions of trends and developments in Multicity network. The survey –called the ‘interpretation survey’- was held in March and April 1999. The main intention was to collect additional information to the often incomplete picture of the individual city reports. This survey among the experts reveals a kind of condensed summarising interpretation of the overall development of the drug situation in Europe and its results can be regarded as an expert validation measure of some of the findings of the previous analysis of indicator data.

The survey pursued following aims:

- to assess changes in the relative order of prevalences of individual drugs;
- to obtain a perceptual notion of drug trends in addition to trends to be observed from data or as an alternative when data are not yet available;
- to get more insight into the orientation of local drug policy as a frame of reference for observed and perceived trends and developments

The survey questionnaire was distributed to 75 experts participating in the Multicity network in the second half of the 1990s. Due to organisational problems the experts of the Russian cities could not be included in the survey. 30 completed questionnaires have been returned. However, in the target population were many experts who in the network act or have acted as substitutes for others and referred to them for the response. If we account for these “doubles” the response increases to 55 (73%).

The response covers 26 cities, 16 from Western Europe and 10 from Eastern Europe, including 3 cities not participating in the Multicity data collection (Luxembourg, Bucharest, Zagreb).

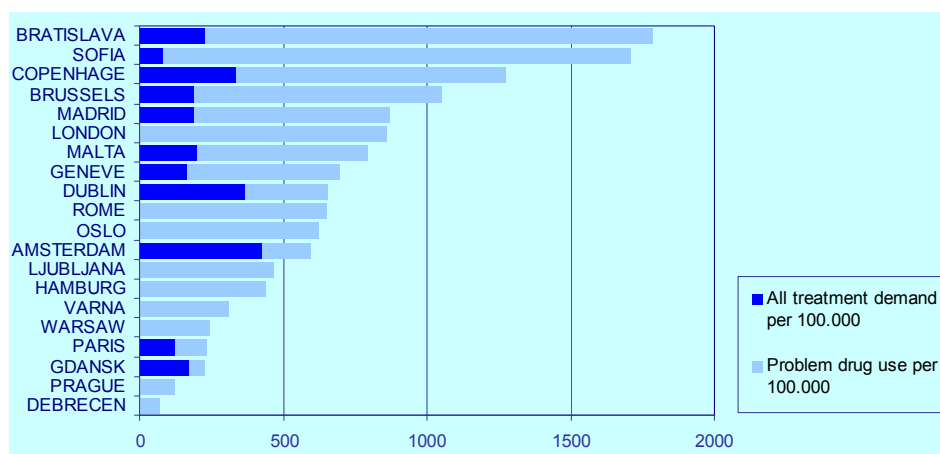
## PROBLEM DRUG USE

Until 1997 the Multicity network did not collect information about estimates of problem drug use and with the 1998 updates only 5 cities provided an estimate.

In the interpretation survey we had defined “problem drug users” as drug users who are in need of treatment. For 20 cities of the multi-city network we received an estimate. It should be remarked that in most cases the figure is an estimation of only one –informed- expert. The figures have been transformed into rates per 100.000 and are compared to the city’s figures of all treatment demand in 1997 or 1998.

As in the case of other indicators, we find considerable differences in indicator values between the cities of the network.

*Estimate of problem drug use and assumed proportion in treatment, 1997-1999*



## PREVALENCE

Information about drug prevalence among the general population is often not available at city level. To a lesser extent the same holds for data about drug prevalence in the treated population. Based on the qualitative sections of the city reports we assume nevertheless that most experts have a general picture of the developments in relative importance of specific drugs used in their community. In the interpretation survey we therefore asked to estimate from informed experience rank orders of prevalence for individual drugs in the early and late 1990s, both among the general population and among problem drug users in need of treatment.

The results provide some insight in developments over time and the problem aspects of individual drugs. We present these results as sets of “illicit pyramids”, differentiated between Eastern and Western Europe and between large and smaller cities. As before the split between large and smaller cities has been set at a population of 1 million. Substances are listed in the pyramids in reverse order of prevalence. The order follows the average rank order as indicated by the city experts. In cases of equal ranking, the substance with the greater pharmacological potency is ranked higher.

A comparative look at the pyramids reveals some remarkable differences, in particular between the Eastern- and Western-European cities. We just point to some striking observations.



- There is obviously a dramatic loss of importance of inhalants in the Eastern European cities in the course of the 1990s. To a lesser extent this also applies to “opium”, which in this context should be read as homemade opiates, at least in the general population. In the course of the democratisation process and the associated opening of the borders and access to new cultural influences, 'new' drugs have gained attractiveness and replaced previous drug use patterns.
- Apart from cannabis, different drugs seem to be of different importance in the general population of East and West. This variation could be blamed on different, not at least sub-culture driven, drugs markets and the proximity to different main drug trafficking routes. For instance the proximity of Eastern Europe to the principal poppy-growing areas versus the proximity of Western Europe to the main cocaine trade routes.
- Generally speaking, opiates seem to be more important in the Eastern cities, whereas stimulating drugs –in particular cocaine- seem to be more important in the West. This is also reflected in the 'problem use pyramids' and the previous multiple classification analyses. The question remains, whether cocaine in due time will reach such a status in the Eastern cities as it was the case in Western Europe compared to the United States.

*Prevalence general population - Early 1990s*

EASTERN EUROPE	WESTERN EUROPE	rank order
Crack	Crack	9
Cocaine	Inhalants	8
Ecstasy	O p i u m	7
Hallucinogens	Ecstasy	6
Amphetamines	Hallucinogens	5
<b>H e r o i n</b>	<b>H e r o i n</b>	4
<b>O p i u m</b>	<b>C o c a i n e</b>	3
<b>C a n n a b i s</b>	<b>A m p h e t a m i n e s</b>	2
<b>I n h a l a n t s</b>	<b>C a n n a b i s</b>	1

*Prevalence general population – Late 1990s*

EASTERN EUROPE	WESTERN EUROPE	rank order
Crack	Crack	9
Opium	Inhalants	8
Cocaine	O p i u m	7
Hallucinogens	H e r o i n	6
I n h a l a n t s	Hallucinogens	5
<b>E c s t a s y</b>	<b>A m p h e t a m i n e s</b>	4
<b>A m p h e t a m i n e s</b>	<b>E c s t a s y</b>	3
<b>H e r o i n</b>	<b>C o c a i n e</b>	2
<b>C a n n a b i s</b>	<b>C a n n a b i s</b>	1

*Primary drug among users in need of treatment – Early 1990s*

EASTERN EUROPE	WESTERN EUROPE	rank order
Crack	Ecstasy	9
Ecstasy	Inhalants	8
Cocaine	Crack	7
Amphetamines	Hallucinogens	6
Hallucinogens	Cocaine	5
<b>Cannabis</b>	<b>Amphetamines</b>	4
Inhalants	Opium	3
Opium	<b>Cannabis</b>	2
<b>Heroin</b>	<b>Heroin</b>	1

*Primary drug among users in need of treatment – Late 1990s*

EASTERN EUROPE	WESTERN EUROPE	rank order
Crack	Hallucinogens	9
Cocaine	Inhalants	8
Hallucinogens	Opium	7
Ecstasy	Ecstasy	6
Inhalants	Crack	5
<b>Cannabis</b>	<b>Cannabis</b>	4
<b>Opium</b>	<b>Amphetamines</b>	3
Amphetamines	<b>Cocaine</b>	2
<b>Heroin</b>	<b>Heroin</b>	1

- There are also some striking observations regarding particular drugs. In the West-European cities cannabis is without exception the most common illicit drug. Heroin is both in the west and the East the number one 'problem drug'. Crack is contrary to common drug political discourse and media hype of minor importance in the general drug using patterns and even in the user groups deemed to be in need of treatment. Though, it has to be said that crack has achieved a slightly higher rank in the course of the 1990s in Western European cities.
- The 'classic' drugs of the Eastern European scene in the early 1990s, inhalants and homemade opiate extracts, are being replaced by heroin and amphetamines. The observation might even have been more prominent if the Russian experts had participated in the survey. The change of the 'general prevalence pyramids' in the course of the 1990s confirms the hypothesis that the Eastern and Western European developments within this phenomenological context seem to converge.
- A multiple classification analyses on the rank orders of the various drugs does not show significant differences between the smaller and larger cities with regard to drug using patterns in the general population. But looking at the 'problem use pyramids' we see some striking differences. At the beginning of the 1990s we can observe different perceptions of 'problem drug use', which seem to have diminished at the end of the 1990s, when the pyramids are looking rather equal.

*Prevalence general population –Early 1990s*

CITIES < 1Mio.	CITIES > 1Mio.	rank order
Crack	Crack	9
Ecstasy	Ecstasy	8
Cocaine	Opium	7
Hallucinogens	Inhalants	6
O p i u m	H e r o i n	5
Amphetamines	C o c a i n e	4
I n h a l a n t s	Hallucinogens	3
H e r o i n	A m p h e t a m i n e s	2
C a n n a b i s	C a n n a b i s	1

*Prevalence general population – Late 1990s*

CITIES < 1 Mio.	CITIES > 1Mio.	rank order
Crack	Crack	9
Opium	Opium	8
Inhalants	Inhalants	7
Hallucinogens	Hallucinogens	6
Cocaine	H e r o i n	5
E c s t a s y	C o c a i n e	4
Amphetamines	A m p h e t a m i n e s	3
H e r o i n	E c s t a s y	2
C a n n a b i s	C a n n a b i s	1

*Primary drug among users in need of treatment – Early 1990s*

CITIES < 1 Mio.	CITIES > 1 Mio.	rank order
Crack	Ecstasy	9
Ecstasy	Crack	8
Hallucinogens	Hallucinogens	7
Amphetamines	Cannabis	6
Cocaine	Inhalants	5
Inhalants	C o c a i n e	4
O p i u m	A m p h e t a m i n e s	3
C a n n a b i s	O p i u m	2
H e r o i n	H e r o i n	1

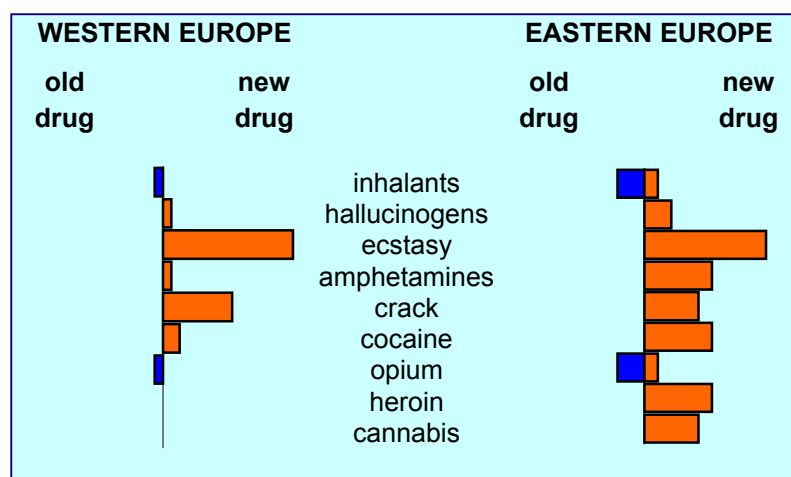
*Primary drug among users in need of treatment – Late 1990s*

CITIES < 1 Mio.	CITIES > 1 Mio.	rank order
Hallucinogens	Hallucinogens	9
Inhalants	Crack	8
Crack	Ecstasy	7
Ecstasy	Inhalants	6
O p i u m	O p i u m	5
C o c a i n e	C o c a i n e	4
C a n n a b i s	C a n n a b i s	3
A m p h e t a m i n e s	A m p h e t a m i n e s	2
H e r o i n	H e r o i n	1

## NEW AND OLD DRUGS

Although the pyramids already provide an indication of emerging and disappearing drugs, we also asked the experts to identify which drugs have appeared (new drugs) and which ones have vanished (old drugs) from the cities' drug scenes. The response confirms the changes in the illicit pyramids and we can make the following additional observations.

*New and old drugs in Eastern and Western Europe in the 1990s;  
bars relative to percentage of experts labelling a drug as "new" or "old"*



→ In Eastern Europe most drugs other than inhalants and opium (opiate extracts) are perceived more or less as new drugs. Only a few however consider inhalants and opium today as old drugs, which implies that they have not yet disappeared from the scenes. In the West both ecstasy and crack are observed as new drugs, but nothing seems to have disappeared.

→ The fact that drugs in the perception of the experts do not disappear could be hypothetically interpreted that as soon as substances having achieved a wider spread they hardly totally vanish from the cultural selection of psychoactive substances. Taking hallucinogens as an example: they were used to a wider extent, but limited to particular social subgroups in the late 1960s and early 1970s. Since then, hallucinogens have spread over the social stratum, over different social milieus, and have become well established in the cultural consciousness regarding the use of psychoactive substances. Nevertheless, hallucinogens are still not widely used in the general population.

## TRENDS IN INDIVIDUAL DRUGS

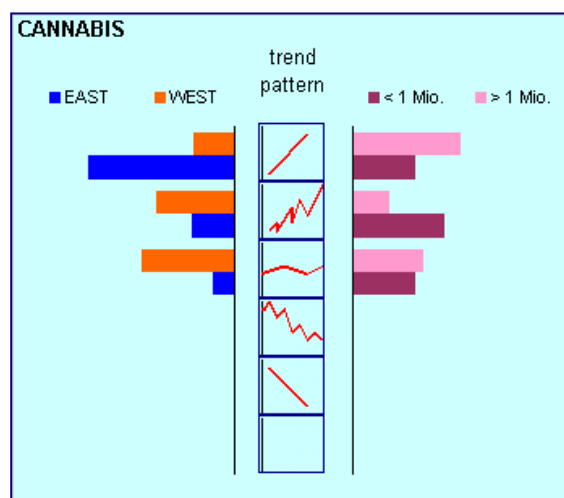
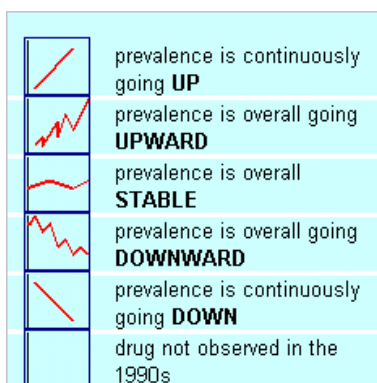
Even at national level most countries do not yet have consistent time series to assess trends in the prevalence of illicit drugs among the general population. On the other hand experts in the field in general will have some notions about what is going on from other sources as the treatment system, the police, prevention activities, etc. As a next step in the fine-tuning of our assessment of local drug use prevalence, we asked in the interpretation survey to assign a perceived trend pattern to individual drugs. Again we present the results in graphic format for large and smaller cities and for Eastern and Western Europe separately. In the graphs the bars are relative to the percentage of experts who perceive the predefined trend pattern as applicable to a substance during the 1990s.

As already observed before, the classic drugs of Western Europe, cannabis and heroin, seem to be of growing importance in Eastern Europe. Almost all city experts of Eastern Europe report up- or upward trends for both cannabis and heroin, compared to only half of the experts in the West. Similar differences can be observed with regard to amphetamines. In contrast, cocaine is typical for Western European cities.

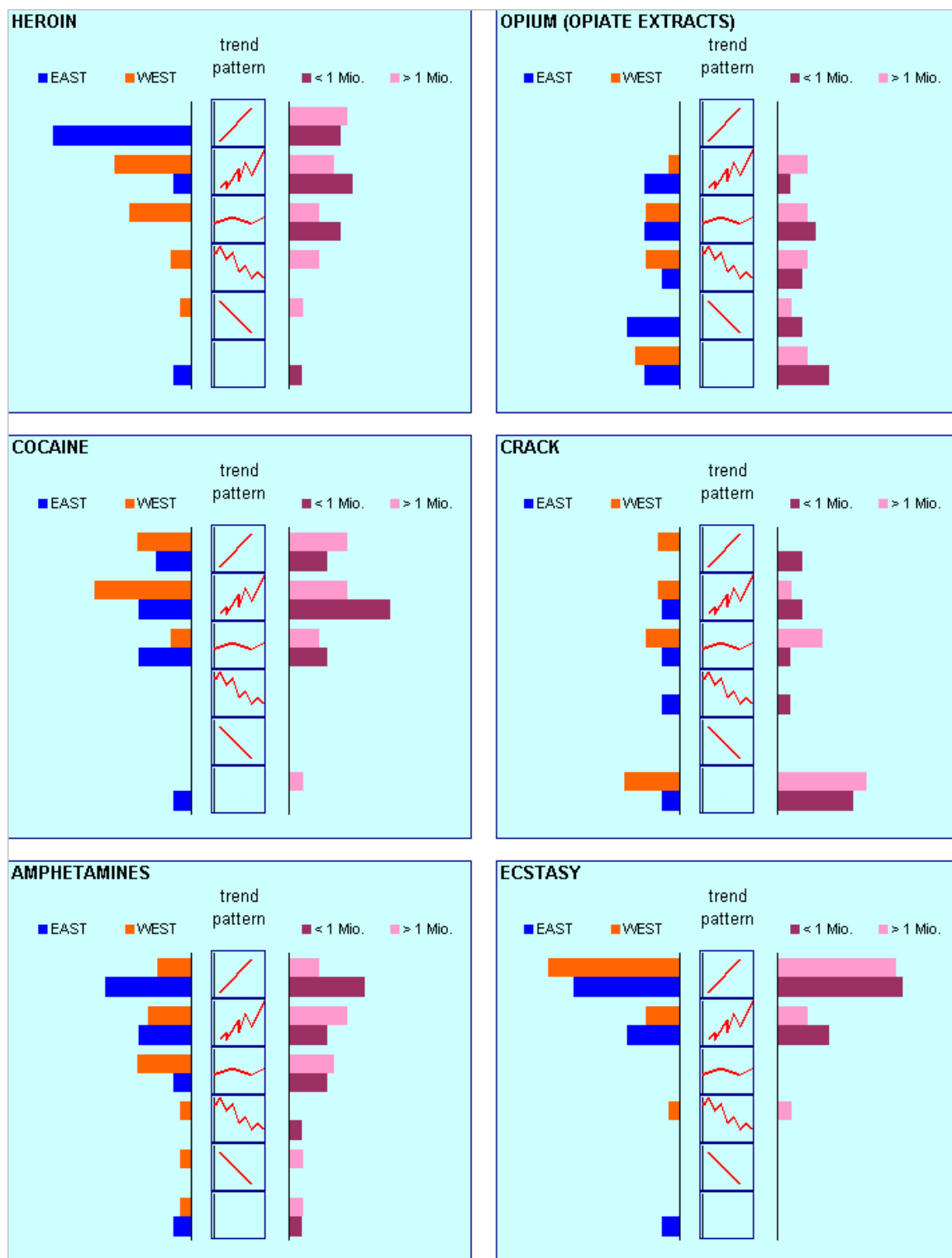
Remarkable is the parallel trend in the use of ecstasy in Eastern and Western Europe. Nearly without exception all cities report a still ongoing up-/upward trend. For crack, the information provided supports the already stated hypothesis of a minor attractiveness of this drug in European cities. For the majority of cities this drug has not yet appeared in the local scene on a noticeable scale.

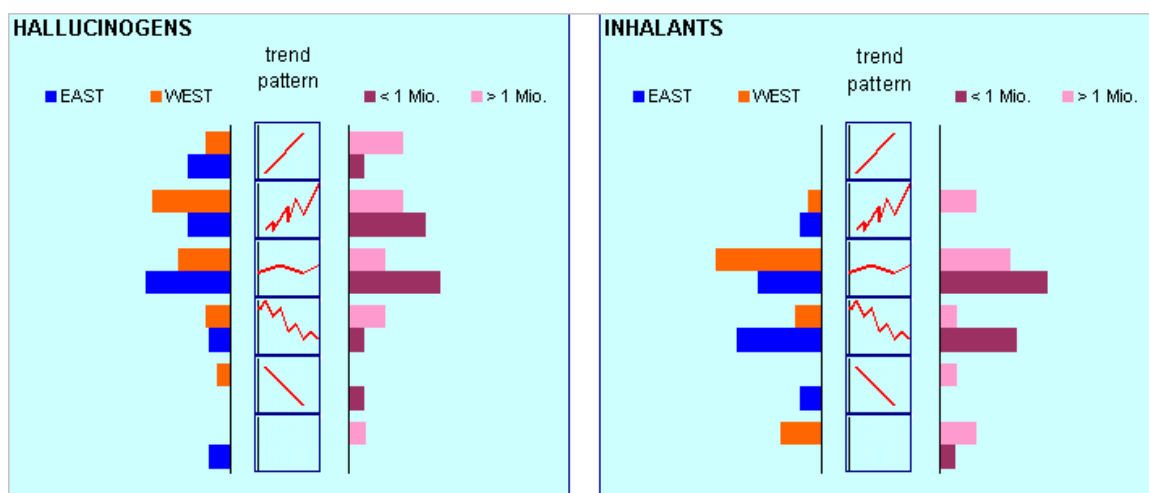
A first comparative glimpse the city size factor does not reveal major differences in the reported trend patterns in the 1990s.

*Perceived trend patterns of cannabis in the 1990s, in Eastern and Western Europe and in large and smaller cities.*



*Perceived trend patterns of drugs in the 1990s*





## EPIDEMIOLOGICAL STAGES

Trend assessment might be one of the main purposes of drug monitoring systems, they give insufficient information about the diffusion of drug use in the community. Even when trends go up, drug use might still be restricted to specific groups or areas. Estimating prevalences and trends separately for all sorts of subgroups is quite problematic, not only because in general we do not have appropriate data on attributes, other than gender and age, of the drug using population, but also because we do not always know in advance which attributes we need to look for.

To obtain at least some impression on diffusion of drug use, we included in the interpretation survey an experimental assessment question. This was placed in the context of the development of a meta-concept of "epidemiological stages" to describe and understand the complex indicator patterns of individual cities. Below we first explain this concept and then return to the results of the interpretation survey.

### Epidemiological stages

In our phenomenological context 'epidemiological stages' refer to a certain distribution level of certain substances in the population of a given area or city. The theoretical construction of the epidemiological stages defined further down is closely linked to the epidemiology's original field of medical sociology. In line with the epidemiologists' main focus directed towards the origin and spread of diseases, our analyses' guiding interest is put on the social background of, and the risk factors associated with, the spread of the use of illicit drugs.

The model of epidemiological stages does not provide any explanations of drug use. It should be seen as an attempt towards a better description of the drug use phenomenon's developments. Further theoretical work will have to make it more precise to better depict drug-using situations, but even the actual stand of the model allows descriptions of the spread of drugs or the diffusion pattern of particular drugs, which make much more sense than common tendencies to label any rise in prevalence rates as an epidemic or threat to society.

To take the example of the "crack-epidemic" in the United States: "The empirical evidence on crack use suggests that politicians and journalists have routinely used the word 'epidemic' and 'plague' imprecisely and rhetorically as words of warning, alarm, and danger. (...) If the word 'epidemic' is used to mean a disease or disease-like condition that is 'widespread' or 'prevalent', then there has never been an epidemic of crack addiction (or even crack use) amongst the vast

majority of Americans. (.....) An 'epidemic of crack use' might be a description of what happened among a distinct minority of teenagers and young adults from impoverished urban neighbourhoods in the mid to late 1980s"<sup>1</sup>

The development of 'epidemiological stages' has to be aware of the circumstance that the spread of psychoactive substances is -in many cases strongly- linked to limits and bounds, which in the first place refer to age and the social stratum. Research on risk factors of drug use and prevalence surveys clearly reveal a close link between certain substances and specific age-cohorts and social-economic groups. A description of prevalence rates of different drugs is not imaginable without reflecting upon the age-structure and the social structure of the (main) user groups. Summarising the respective drug research's actual stand, the social networks -mainly developing along an age and socio-economic divide- of people with whom regularly contacts and closer relationships take place seem to be a crucial social determinant of drug using behaviour. A third element of the stage model consists of the geographic, regional, and local bounds, which are the central differentiation criterion in classical epidemiology. Apart from national differences, geographic differences in the spread of illicit drugs appear mainly in the form of a rural-urban gradient.

The terminology we apply is illustrated and described below.



- 1 **Endemic:** the spread of the particular psychoactive substance is strongly limited to certain age-cohorts, socio-economic groups AND geographic boundaries.
- 2 **Endemic-epidemic:** the trend indicates an exceeding of the use of the substance over age-, social-, OR geographic-boundaries
- 3 **Epidemic:** the usage of the substance is spreading over different age-cohorts, socio-economic groups OR geographic areas
- 4 **Epidemic-pandemic:** the spread of the particular substance is not restricted (anymore) to clearly definable age-cohorts, socio-economic-groups AND geographic areas
- 5 **Pandemic:** the particular substance is strongly spreading over different age-cohorts, socio-economic groups AND geographic areas.

<sup>1</sup> Reinerman, C., Levine, H.G. (1997): The Crack Attack: Politics and Media in the Crack Scare. In: Reinerman, C., Levine, H.G. (eds.): Crack in America. University of California Press, Berkeley/Los Angeles/London: 33f.



It is obvious that stages 1 to 5 are associated with increasing prevalence. In the previous paragraph we introduced a five-point ordinal scale to describe drug use trends. This scale is applicable to all epidemiological stages.

As an example, referring again to the crack 'outbreaks' during the mid and late 1980s in the USA. At the beginning there was a quick rise in the usage of crack observable within narrow socio-economic boundaries linked to ethnic minorities and juvenile age-cohorts and restricted to geographical local areas or districts. This could be described as an endemic situation with an upward-trend. Since then, crack has reached the endemic-epidemic stage in some countries but it is worldwide still far away from an epidemic situation.

It's getting obvious that *different* drugs could and normally do take up *different* epidemiological stages with *varying* developmental trends at the same time. We can, for example, observe in some European countries a stable heroin-using situation on an endemic stage running parallel to an upward trend on an epidemic stage of synthetic drugs.

A clear upward or downward trend could indicate a transition into another (higher or lower) stage. Thus, ups and downs in prevalence rates are 'initial' observations, which give cause for deeper analyses. As already indicated, this concept of epidemiological stages is of descriptive rather than explanatory quality. Closer analyses going beyond the level of describing diffusion patterns are necessary to get insights into the dynamic of epidemiological changes by revealing relevant background variables concerning those identified transition processes. Taking up a lower or higher epidemiological stage could - generally speaking - explained as a (sub-) cultural reflex due to new fashion styles, political movements, trends in the spirit of the age, in the leisure time industry etc. Thus, exploring the background forces of epidemiological transition processes, of the dynamic of diffusion patterns requires an analytical reflection upon (sub-) cultural and socio-economic developments and changes.

The reasons for epidemiological changes could ideally be explored according to theoretical constructs on the phenomenon of deviance as we do find them in sociology and especially in the field of criminology. The basic theoretical assumption is that deviant behaviours - such as drug use - resemble infectious diseases and are spread through peer contacts and influences. We could find a lot of empirical evidence for this assumption of a peer-group based spread referring to the usage of drugs in various studies: "People who come in contact with many people are apparently not only confronted more often with positive definitions of drug use, they also have greater opportunities to use drugs" <sup>2</sup>. Though, the influence of the peer group seems to vary with age. Especially in younger age cohorts the peer association seems to significantly impact drug using behaviour.

The starting point of these theoretical models, named threshold model, critical-mass model or contagion model, is the idea of critical levels of incidence of a phenomenon in populations. If incidence stays below this point, the prevalence tends to gravitate toward some relatively low-level equilibrium. But if incidence reaches the critical point, the process of spread can explode. In other words, an epidemic may occur, raising the incidence to equilibrium at a higher level. In this sense we could say that the epidemiological stages of our model represent different equilibrium levels.

Taking up the epidemiologists' language we also could speak of a 'tipping point', the point at which the usage of a drug can either turn into a serious public-health problem, or, in the case of incidence running below the tipping point or critical point, into a phenomenon remaining restricted to smaller user circles causing no striking social and health problems. Thus, we could speak with regard to our model of a turning point, the point at which the trend of the drug use incidence runs towards a higher or lower epidemiological stage.

It should be remarked that the epidemiological dynamic of incidence running below or above a critical, turning point is non-linear: If the level of the snow in the Alps reaches a critical mass the risk of avalanches exponentially rises. But it depends on many other factors if the snow will avalanche down. The same applies to drugs. A wider spread of drug use is influenced in a large variety of ways by various factors such as, to name just some examples, subculture and youth culture developments (and the herewith associated leisure industry), occupational, and socio-economic structure, prevention programmes, etc.

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<sup>2</sup> Reuband K.-H. [1992] Der Mythos vom einsamen Drogenkonsumenten. Kontakte zu Gleichaltrigen als Determinanten des Drogengebrauchs (The Myth of the Lonely Drug User. Interpersonal Contacts with Peer as Determinants of Drug Use). In: Sucht, 3: 160-172

## Assessment of diffusion patterns

One of the main tasks of the 3rd Multi-City Study should be the interpretation of trends and developments, aiming at a notion or impression of possible critical points and the epidemiological dynamic of the drug use phenomenon. However, with regard to the criteria listed above, in particular those related to geographic and socio-economic bounds we have at present only very limited information available. Therefore, an identification of epidemiological stages can only be based on the respective views and estimations of the Epidemiology Group as an expert panel.

Within this context we have asked the experts in the interpretation survey to mark for each drug listed which of the epidemiological stages as described above applies best to the situation in their city in the late 1990s.

To avoid a priori confusion, we didn't label the stages in the questionnaire, but only provided the qualitative description of each stage.

The survey results are presented in the table below. It should be remarked that the information can only be seen as a first tentative approach, as the experts responding did not necessarily based their views on the same notions. For reasons of simplification average values of the five point stage scales have been calculated in order to assess the 'stage' of each drug in either Eastern or Western Europe.

Drug		Diffusion pattern				
		Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Cannabis	EAST			●		
	WEST				●	
Heroin	EAST		●			
	WEST		●			
Opium / opiate extracts	EAST		●			
	WEST	●				
Cocaine	EAST	●				
	WEST		●			
Crack	EAST	●				
	WEST	●				
Amphetamines	EAST		●			
	WEST		●			
Ecstasy	EAST	●				
	WEST		●			
Hallucinogens	EAST	●				
	WEST	●				
Inhalants	EAST	●				
	WEST	●				

Apart from cannabis, the experts perceive the use of the specified drugs as being mainly restricted to particular age cohorts, social groups and neighbourhoods. Though it has to be said, that some of the substances have taken up already the epidemiological stage number 2, which signalises a certain extension of existing age and social boundaries.

This summarised finding is more or less in line with the findings of general and school population surveys and reflects common findings in drug research, which identifies the use of illicit drugs as a typical juvenile phenomenon. That cannabis, cocaine and ecstasy take up a higher stage in the Western cities, and opium/opiate extracts a higher stage in the Eastern cities is not surprising and supported by the results of the multiple classification analyses before.

According to our first analyses, the city-size split doesn't reveal striking differences. The spread of the use of the various substances does not differ significantly between larger and smaller cities.

Further analysis might link diffusion patterns with the trend patterns. This might give an indication whether a drug is going to reach a higher epidemiological stage or is to settle on a lower stage. Based on the perceived trends discussed before, it can for example be expected that cannabis in the Eastern European cities will reach the higher epidemiological stage which has already been observed in Western European cities.

## GENERAL LOCAL DRUG SITUATION

Combining our notions about epidemiological stages with indicator data related to interventions (treatment, police) and information about actual or perceived orientations of drug policies and interventions might allow us to identify the problem level of the drug phenomenon in individual cities.

In the interpretation survey we presented the experts five levels of problem situations and asked them to name cities as examples for each level, based on their subjective impressions from the city reports of the Multicity network and the “tour de table” discussions at the meetings of the Epidemiology Group during the 1990s. The experts could name any of the 42 cities that participated in the network at any time during the 1990s. The response results in the informed expert impression listed in the table below.

<b>General developments in the 1990s</b> ( <i>n=number of <u>different</u> cities mentioned</i> )	<b>Responses relating to:</b>	
	<b>EASTERN EUROPE</b>	<b>WESTERN EUROPE</b>
Increasing drug problems; situation out of intervention control or developing out of control (n=12)	19	6
Increasing drug problems; low level of control or not (any more) matched by intervention control (n=13)	20	8
Increasing drug problems; situation remains largely under intervention control (n=15)	1	32
Decreasing drug problems (n=8)	--	15
No (serious) drug problems yet (n=7)	8	4

The results again confirm the East-West differentiation we considered in our analysis. The drug situation in Western European cities is perceived to be largely under control of health, police and justice interventions, accompanied by a tendency of decreasing problems. On the other hand, the situation in Eastern European cities is perceived as being largely out of control with an increase of drug problems.

It should be noted however that there also more cities in Eastern Europe than in Western Europe mentioned to have no serious drug problems yet.

